

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04627
Reg. Dist. No.1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 1b

1 day

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

D.C.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

471x-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Hyattsville Convalescent and Rest Home

d. STREET ADDRESS

1620 Ridge Place, S.E.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

April

13

19 59

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

white

WIDOWED DIVORCED

April 21, 1882

76

Months

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Lieutenant (retired)

Fire Department

Dis. of Columbia

U.S.A.

13. FATHER'S NAME

Henry Allman

14. MOTHER'S MAIDEN NAME

Louise Goss

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

none Mrs Viola Allman; same address as # 2.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral vascular accident

INTERVAL BETWEEN
ONSET AND DEATH

331X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Arteriosclerosis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.
20d. INJURY OCCURRED
White at work Not white at work
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
20f. (City or town) (County) (State)21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined cause .ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

April 13, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State)

Burial

4-16-59

Cedar Hill

Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Lemmons Bros. 1661 Good Hope Rd SE Wash 20002

24a. REC'D BY REGISTRAR
DATE APR 15 '5924b. REGISTRAR'S SIGNATURE
Cathleen L. Hayes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used for a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4651

CERTIFICATE OF DEATH

04628

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Cheverly		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Alsop
4. DATE OF DEATH April 21	Month April	Day 21	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20 1959
9. AGE (In years lost birthday) yrs. 13	10. IF UNDER 1 YEAR Months 13	11. IF UNDER 24 HRS. Days 13	12. Hours 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME John W. Alsop	14. MOTHER'S MAIDEN NAME Gloria J Auth		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Gloria J	17. INFORMANT Mother	Address Address same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Aspiration - Premature 7 mos (cesarean) (c) DUE TO Aleurotox Placenta - Section			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. April 20, 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 20, 19 59 to April 21, 19 59 that I last saw the deceased alive on April 21, 19 59 , and that death occurred at 8:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED Arthur S. Trahan 4/21/59			
ACTUAL SIGNATURE Gascon W Kelley M.D. 6124-41/11 One Hyatt 4/21/59	PHYSICIAN'S NAME (Type) Dr. Kelly		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.	ADDRESS 207717/XV3	24a. REC'D BY REGISTRAR DATE APR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4652

CERTIFICATE OF DEATH

04629

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 2014 24 Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY		First B	Middle B	Last ATHEY	4. DATE OF DEATH Month 4	Day 21	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/20/59	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Esein Athey		14. MOTHER'S MAIDEN NAME Mary Donaldson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 770.0 DUE TO Hydrops Fetalis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Erythroblastosis Fetalis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-20 , 1959, to 4-21 , 1959, that I last saw the deceased alive on 4-21 , 1959, and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D.Bauer M.D.		ADDRESS (Street, city or town, state) 2513 Brucklidge Rd.		DATE SIGNED 4-21-59			
PHYSICIAN'S NAME (Type) R.D. BAUER M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/25/59		22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gerry W. Penn		ADDRESS Jr Administrator		24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF HAWAII - DEPARTMENT OF STATE

DEPARTMENT OF STATE

f

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4653

CERTIFICATE OF DEATH

04630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>		d. STREET ADDRESS <i>19344 Annapolis Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial Hospital</i>				4. DATE OF DEATH <i>April 1</i>		Month	Day	Year	
3. NAME OF DECEASED (Type or print) <i>Karl</i>		First	Middle	Last		25	19	59	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 16, 1887</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>XXXX Ref.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William Austin</i>		14. MOTHER'S MAIDEN NAME <i>Emily Glazier</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife-Mrs. Virginia M. Austin - As above</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i>									
INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension, Chronic urinary tract infection, Prostalgia</i>									
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Blow to head</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Colmar Manor</i>		(County)	(State)
21. I certify that I attended the deceased from <i>1958</i> , to <i>4-27</i> , <i>1959</i> , that I last saw the deceased alive on <i>4-26</i> , <i>1959</i> , and that death occurred at <i>12:35 AM</i> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
DATE SIGNED									
ACTUAL SIGNATURE <i>D. R. Pendie</i>		M.D.							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/29/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. J. Lavelle Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

KANSAS STATE DEPARTMENT OF HEALTH—SAFETY

CERTIFICATE OF DEATH

20 SEP 1951

MURKIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4654

CERTIFICATE OF DEATH

04631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 15 Hyattsville 4310 Jefferson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Lost		4. DATE OF DEATH Month Doy Year April 28 1959	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 26 Mar. 1885		9. AGE (In years at birthday) 74 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John James Sweeney		14. MOTHER'S MAIDEN NAME Martha E. Harfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT none W. Howard Bell	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 DUE TO Sub acute Bacteraemic Toxemia		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Sub acute Bacteraemic septicemic (c) + alcohol ing on bim sec to sept embol.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-13, 1947, to 4-28, 1947, that I last saw the deceased alive on 4-28, 1947, and that death occurred at 7:31 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1932 Queen Street Rd. DATE SIGNED 4/28/59	
ACTUAL SIGNATURE Ronald Fleischer, M.D.			
PHYSICIAN'S NAME (Type) Dr. Ronald Fleischer, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/2/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Waller's Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
ADDRESS Mt. Rainier Md.		24b. REGISTRAR'S SIGNATURE Arthur & Anna	

WISCONSIN STATE DEPARTMENT OF ELECTIONS

CERTIFICATE OF DEATH

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04632

Reg. Dist. No.

4655

Item 12 File # 6241 2-1-59 et

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
Prince Georges MARYLAND		a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Cheverly	D.O.A.	X Kermelkoxwtx Beaver Heights					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
Prince Georges General Hospital		4626 R. Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Cesare			Baroni	April	XX	26	19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 22, 1890	68 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired		Barber		Italy		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unknown		Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				Mary Y. Baron; same address as # 2.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute congestive heart failure	
442X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Cardiovascular renal disease	
DUE TO			
(c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
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ACTUAL SIGNATURE	John T. Maloney	DATE SIGNED
EXAMINER'S NAME (Type)	John T. Maloney, M.D.	26

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
Burial	4-28-59	Washington Nat Cem.	Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
J. W. Lee Sons	Wash. D.C.	DATE APR 28 '59	Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4706

CERTIFICATE OF DEATH

04633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.		d. STREET ADDRESS 1676 32nd St NW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROYDEN	Middle EUGENE	Last BEEBE	4. DATE OF DEATH JR	Month APRIL	Day 29	Year 1959
5. SEX MALE	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1908	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR yrs. Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maj Gen USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) Fort Douglas, Utah			
13. FATHER'S NAME Royden E. Beebe, Sr.		14. MOTHER'S MAIDEN NAME Sarah Reid Park					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1932 to 1959 579-52-9072		17. INFORMANT Wife Mrs. Royden E. Beebe Jr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 420.0 (b) DUE TO 6 Yrs. (c)						INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ARLINGTON NATIONAL		20f. (City or town) (County) (State) ARLINGTON VA.	
21. I certify that I attended the deceased from 29 April 1959 , to 29 April 1959 , that I last saw the deceased alive on 29 April 1959 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 29 April 1959							
ACTUAL SIGNATURE <i>Thomas G Briggs</i>		M.D. USAF Hospital Andrews					
PHYSICIAN'S NAME (Type) THOMAS G BRIGGS, CAPT, USAF (MC)		Andrews AFB, Wash 25, D. C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL MAY 4, 1959		22b. DATE THEREOF MAY 4, 1959		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		ADDRESS 816 H St. N.E.		24a. REC'D BY REGISTRAR DATE MAY 4 1959		24b. REGISTRAR'S SIGNATURE Contin S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4707

CERTIFICATE OF DEATH

04634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Bruce Georges MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Surralland Md		4 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) / OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4450 White Hall Rd Washington 2391		Upper Marlboro Md near Metwood, Md	
3. NAME OF DECEASED (Type or print)		First	Middle
Rosa Lee Binger			Last
4. DATE OF DEATH		Month	Day
		April	15
		Year	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		XX White	8. DATE OF BIRTH
		March 5 1870	9. AGE (In years from birthday) yrs.
		89	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housekeeper		xx Home	Princ Georges Co., Md., U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Benj. F. Duckett		Rebecca Kingsbury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		none	Fred K Binger Upper Marlboro Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Acute Congestive Cardiac Failure 24 hours	
(b) DUE TO		Chronic Arteriosclerotic Myocarditis unknown	
(c) DUE TO		General Arteriosclerosis unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
		(County)	
		(State)	
21. I certify that I attended the deceased from Jan 11 1959 19 to April 15, 1959, that I last saw the deceased alive on April 15, 1959, and that death occurred at 1715 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type)		Paul C Van Natta M.D. 5540 Silver Hill Rd SE 4/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM
Burial		4/18/59	Cedar Hill Cemetery
22d. LOCATION (City, town, or county)		(State)	
Suitland		Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR	
		DATE APR 24 '59	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	60	M	CHRONIC RHEUMATOID ARTHRITIS
ADDRESS	STREET	CITY	STATE
100 W. BROAD ST.	SUITES 100 & 200	SAVANNAH	GA
NAME OF DOCTOR	ADDRESS	STREET	CITY
DR. JAMES M. COOPER	100 W. BROAD ST.	SUITES 100 & 200	SAVANNAH
NAME OF FUNERAL DIRECTOR	ADDRESS	STREET	CITY
WILLIAM H. COOPER	100 W. BROAD ST.	SUITES 100 & 200	SAVANNAH
DATE OF DEATH	TIME	AGE	WEIGHT
NOVEMBER 12, 1968	10:00 A.M.	60	160 LBS.
TIME OF DEATH	TIME OF AUTOPSY	TIME OF EXAMINATION	TIME OF EXAMINATION
NOVEMBER 12, 1968	NOVEMBER 12, 1968	NOVEMBER 12, 1968	NOVEMBER 12, 1968
NAME OF PERSON SIGNING	RELATIONSHIP	ADDRESS	STREET
DR. JAMES M. COOPER	DOCTOR	100 W. BROAD ST.	SUITES 100 & 200
DATE SIGNED	NOVEMBER 12, 1968	TIME	10:00 A.M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04635

Reg. Dist. No.

4656

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle HENRY	Last BLACK		
4. DATE OF DEATH April 14, 1959	Month Month	Day Day	Year Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1877		
9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Hannah				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. Spanish Amer.	17. INFORMANT Florence M. Black	Address 7014-Varnum St. Landover Hills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. PROSTATIC HYPERPLASIA + PYELONEPHRITIS		DUE TO (b) 6 months			
		DUE TO (c) 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ACIDOSIS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Revdale, Md.	(County) Revdale, Md.	(State) Md.
21. I certify that I attended the deceased from 4/13/59 , 1959 to 4/14/59 , 1959, that I last saw the deceased alive on 4/13/59 , 1959, and that death occurred at 4A , M, from the causes and on the date stated above. ACTUAL SIGNATURE Albert Roth M.D. ADDRESS (Street, city or town, state) Revdale, Md. DATE SIGNED 4/14/59					
PHYSICIAN'S NAME (Type) Dr. Albert Roth, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-16-1959	22c. NAME OF CEMETERY OR CREMATORIY Scottdale Cemetery	22d. LOCATION (City, town, or county) Scottdale, Pennsylvania	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home - Mt. Rainier, Md.	ADDRESS Inc.	24a. REC'D BY REGISTRAR DATE APR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Haas		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4708

CERTIFICATE OF DEATH

04636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB Wash 25, DC		c. LENGTH OF STAY IN 1b 15 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		d. STREET ADDRESS 8 ORiley Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Una	Middle Lester	Last Boyles	4. DATE OF DEATH April	Month 24	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 6, 1902	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 1	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Clerk		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wyley Bridges		14. MOTHER'S MAIDEN NAME Dacia Elvira Suttle Fourtune		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ralph Cordovan		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertensive Cardiovascular Disease (c)	
						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington National		20f. (City or town) (County) (State) Suitland. Maryland	
21. I certify that I attended the deceased from April 24, 1959 , to April 24, 1959 , that I last saw the deceased alive on April 24, 1959 , and that death occurred at 4:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hospital Andrews DATE SIGNED Reginald P. McManus CAPT USAF (MC) Andrews AFB., Washington 25, DC April 24, 1959							
ACTUAL SIGNATURE <i>Reginald P. McManus MC</i>		PHYSICIAN'S NAME (Type) REGINALD P. MC MANUS CAPT USAF (MC) Andrews AFB., Washington 25, DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4.27. 1959		22c. NAME OF CEMETERY OR CREMATORIUM Washington National		22d. LOCATION (City, town, or county) (State) Suitland. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.W. Lees Son</i>		ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		ADDRESS		NAME OF DOCTOR	
JAMES J. MURPHY		101 E. 36TH ST.		DR. H. H. COOPER	
AGE		SEX		TIME OF DEATH	
65		M		10:30 A.M.	
WEIGHT		HEIGHT		CAUSE OF DEATH	
160 lbs		5' 7"		Cerebral Hemorrhage	
RELATIONSHIP TO DECEASED		TIME OF DEATH		NAME OF HOSPITAL	
Son		10:30 A.M.		Baltimore City Hospital	
MATERIAL TESTED		TESTS		TESTER	
None		None		None	
NAME OF PERSON FILING CERTIFICATE		SIGNATURE		STAMP	
Dr. H. H. Cooper				Baltimore City Hospital	
APPROVED		APPROVED		APPROVED	
Dr. H. H. Cooper				Baltimore City Hospital	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04637

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		4657						04637				
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)										
a. COUNTY Prince George		b. STATE Maryland						c. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General		d. STREET ADDRESS 5704-29th. Place						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARIE		First C.	Middle BRADLEY	Lost	4. DATE OF DEATH April 3,	Month April	Day 3	Year 19 59				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1890	9. AGE (In years at birthday) 68	yrs.	IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Hooper		14. MOTHER'S MAIDEN NAME Lillian Burns										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, ever unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur Bradley 7930-18th. Ave. Adelphi Md.								
Address												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure												
442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cardio Vascular Renal Heart Disease												
DUE TO (b) Cardio Vascular Renal Heart Disease												
DUE TO (c) Cardio Vascular Renal Heart Disease												
INTERVAL BETWEEN ONSET AND DEATH												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED April 4, 1959				
EXAMINER'S NAME (Type) John T. Maloney, M.D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-'59		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland		(State) Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 5801-Cleve. Ave. Riverdale						24a. REC'D BY REGISTRAR MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans		
								DATE APR 7 '59				
VS. A15ME 5M 2/57												

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4709

CERTIFICATE OF DEATH

04638

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24									
PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.		c. LENGTH OF STAY IN lb Glenn Dale (RURAL) 3 yrs., 11 days		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3		d. STREET ADDRESS 666 Kenilworth Ave., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																									
NAME OF DECEASED (Type or print) Jack		First Middle Jack Brown		DATE OF DEATH April 29 1959		Month Day Year																																																	
SEX Male		COLOR OR RACE Negro		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DATE OF BIRTH 2/4/1882		AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.																																											
USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (State or foreign country) Oklahoma		CITIZEN OF WHAT COUNTRY? U.S.A.																																																	
FATHER'S NAME William Brown		MOTHER'S MAIDEN NAME Ellen Tillman																																																					
WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		SOCIAL SECURITY NO. 200-07-3310		INFORMANT Decedent		Address																																																	
CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Pulmonary tuberculosis				INTERVAL BETWEEN ONSET AND DEATH 14 yrs.																																																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PNEUMONITIS RT MIDDLE & LOWER COBES Pulmonary emphysema and fibrosis: cor pulmonale						WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																	
ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b.																																																					
TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e.		(City or town) 20f.		(County) 20g.		(State) 20h.																																													
I certify that I attended the deceased from 4/18/1956 to 4/29/1959, that I last saw the deceased alive on 4/29/1959, and that death occurred at 10:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Moe Weiss		M.D.		Glenn Dale Hospital		ADDRESS (Street, city or town, state) Glenn Dale Hospital		DATE SIGNED 4/29/59																																															
PHYSICIAN'S NAME (Type) Moe Weiss																																																							
BURIAL, CREMATION, REMOVAL (Specify) 5-6-59		DATE THEREOF 5-6-59		NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		LOCATION (City, town, or county) Washington, D. C.		(State)																																															
FUNERAL DIRECTOR'S SIGNATURE Palmer Funeral Home		ADDRESS 412-41st, N.E. Wash. D.C.		RECD BY REGISTRAR MAY 6 '59		REGISTRAR'S SIGNATURE Arthur & Thorne																																																	

DEPARTMENT OF STATE - DIVISION OF RECORDS - NEVADA

CERTIFICATE OF DEATH

RECEIVED
MAY 17 2011

RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04639

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4710 Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS X Oxon Hill 4534 Wheeler Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Richard C	Middle	Last Brown	DATE OF DEATH Month April	Year 6	
4. SEX Male		5. COLOR OR RACE Colored	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/09	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr.		14. MOTHER'S MAIDEN NAME Estelle Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Shock		Address Sarah Brown-S.E. Wash., D.C.	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o)		916.0 DUE TO		Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO		DUE TO		Universal burns of body - Charring			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Occupant of house that burned to ground		20c. TIME OF INJURY Month, Day, Year 4-6 1959		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Oxon Hill		20g. (County) Md.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		EXAMINER'S NAME (Type) JAMES I. Boyd		DATE SIGNED April 7, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/10/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Mason Funeral Home, Inc.		ADDRESS 2000 Nichols Ave, S.E. #17		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Hayes	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Mason Funeral Home, Inc.		ADDRESS 2000 Nichols Ave, S.E. #17		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Hayes	
VS. A15ME BM 2/57		DATE APR 14 '59					

MANUFACTURE, DISTRIBUTION & EXHIBITION OF HAZARD-GARMENTS
MEDICAL EXAMINER'S CERTIFICATE OF DOTH

STATE OF NEW YORK

No. 12

John Doe, deceased

Reported to the Coroner by Dr. John Doe
on the 1st day of January 1919

John Doe, deceased
by Dr. John Doe

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04640

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb Dead on arrival	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 5007 Southern Avenue	
3. NAME OF DECEASED (Type or print) Robert W. William Brownlee		4. DATE OF DEATH April 29, 1959	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1895
9. AGE (In years from birthday) 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper	11. KIND OF BUSINESS OR INDUSTRY Automobile	12. BIRTHPLACE (State or foreign country) Texas
13. FATHER'S NAME Robert William Brownlee	14. MOTHER'S MAIDEN NAME Frances Leatherwood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes WW 1	16. SOCIAL SECURITY NO.	17. INFORMANT Ethel King Brownlee, same as # 2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 442 X Acute congestive heart failure DUE TO			
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED April 30, 1959
EXAMINER'S NAME (Type) XXXXX James I. Boyd	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, Cremation, Removal (Specify) Burial	22b. DATE THEREOF 5-4-59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 1 1959	24b. REGISTRAR'S SIGNATURE Clothing & Frame

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4659

Items #13 & 14 - See back cont. 2013

04641

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (27) Seat of Govt.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 7010 Greig Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Bryant	4. DATE OF DEATH	Month April	Day 6	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4/3/59	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 3	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Billy C. Bryant		14. MOTHER'S MAIDEN NAME Sally Mayne Firestone					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Sally Bryant Mother		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Tuberculosis (c) Aortic Atresia							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1959 , to April 6, 1959 that I last saw the deceased alive on April 6, 1959 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Cheverly, Md.							
DATE SIGNED Cheverly, Md. 4/7/59							
ACTUAL SIGNATURE <i>John Kehoe</i>							
PHYSICIAN'S NAME (Type) Dr. John Kehoe							
220. BURIAL, CREMATION REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4/9/59		22c. NAME OF CEMETERY OR CREMATORIUM Prince George's General Hospital		22d. LOCATION (City, town, or county) Cheverly Md	
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W Penn Jr</i>		ADDRESS Administrator.		24a. REC'D BY REGISTRAR APR 13 1959		24b. REGISTRAR'S SIGNATURE Charles S. Frank	
				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFERENCES

16

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4711

CERTIFICATE OF DEATH

04642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		d. STREET ADDRESS 108-- Park Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108-- Park Blvd.				d. STREET ADDRESS 108--Park Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORA		Middle M.		Last BRYANT		4. DATE OF DEATH Apr. 28th	Month Day Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 14, 1895		9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse-Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph M. Armiger		14. MOTHER'S MAIDEN NAME Agnes V. Atwell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Richard A. Bryant		Address 108- Park Blvd. Silver Hill, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 33IX		DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertension		(c)				13 years+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 2520 Pa. Ave S.E. Washington DC		20f. (City or town) Suitland, Maryland	(County) (State)
21. I certify that I attended the deceased from July 1, 1946 , to April 27, 1959 , that I last saw the deceased alive on April 28, 1959 , and that death occurred at 11:57 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 4/27/59	
ACTUAL SIGNATURE James C. Cawood							
PHYSICIAN'S NAME (Type) James C. Cawood							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1st, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simpson Bros.		ADDRESS 1661--Good Hope Rd., SE Washington 20, DC		24a. REC'D BY REGISTRAR APR 30 '59		24b. REGISTRAR'S SIGNATURE Ervin S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8. FROM THE STATE TO THE NATIONAL STATE COUNCIL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG241 4-27-59 et

04643

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleverly		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxon Hill		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			d. STREET ADDRESS 6796 Tucker Rd.			
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catherine First E. Middle Buckler		Lost		4. DATE OF DEATH Apr.	Month Day Year 20 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/06	9. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, D.C.		
13. FATHER'S NAME James Langley			14. MOTHER'S MAIDEN NAME Julia Ida Langley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lula May Chaney 5018- 25th. Place S.E.		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Breast with Gen. Metastasis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour o.m. p.m.	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bladensburg	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from Apr. 13, 1959, to Apr. 20, 1959, that I last saw the deceased alive on Apr. 20, 1959, and that death occurred at 11:15PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 2324 Everson St. S.E. Prince George, Maryland
ACTUAL SIGNATURE <i>Bernard F. Peacock</i> M.D.						DATE SIGNED 1959
PHYSICIAN'S NAME (Type) Bernard F. Peacock						Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 23-59	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Bladensburg, Maryland.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Summers Bros</i>			ADDRESS 1661 Royal Hope Rd. S.E.	24a. REC'D BY REGISTRAR DATE APR 22 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur & Sons</i>	

CERTIFICATE OF DEATH

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04644

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4661

1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Washington, D.C. 47 X-3 ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4704 Edmonston Road		d. STREET ADDRESS		2505 Rhode Island Ave N.W.		
3. NAME OF DECEASED (Type or print)		First Planter	Middle Bush	Last	4. DATE OF DEATH	Month April	Day 27	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR Months 51 yrs.	IF UNDER 24 HRS. Days Hours Min.	
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	3-4-08				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Iron worker		Construction		Alabama		U.S.A.		
13. FATHER'S NAME John Bush				14. MOTHER'S MAIDEN NAME Sally Peal				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 420-12-3310 17. INFORMANT John Walker; 1507 R.I. Avenue, Washington, D.C. Address Crematorium				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Hemorrhage and shock				
54-10 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Hemorrhage from duodenal ulcer				
DUE TO (b) (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED April 27, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-59		22c. NAME OF CEMETERY OR CREMATORIAL WASHINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) BUTLAND, MARYLAND (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS & CO INC.		ADDRESS Washington DC		24a. REC'D BY REGISTRAR MAY 1 1959		24b. REGISTRAR'S SIGNATURE Arthur & Kraus		

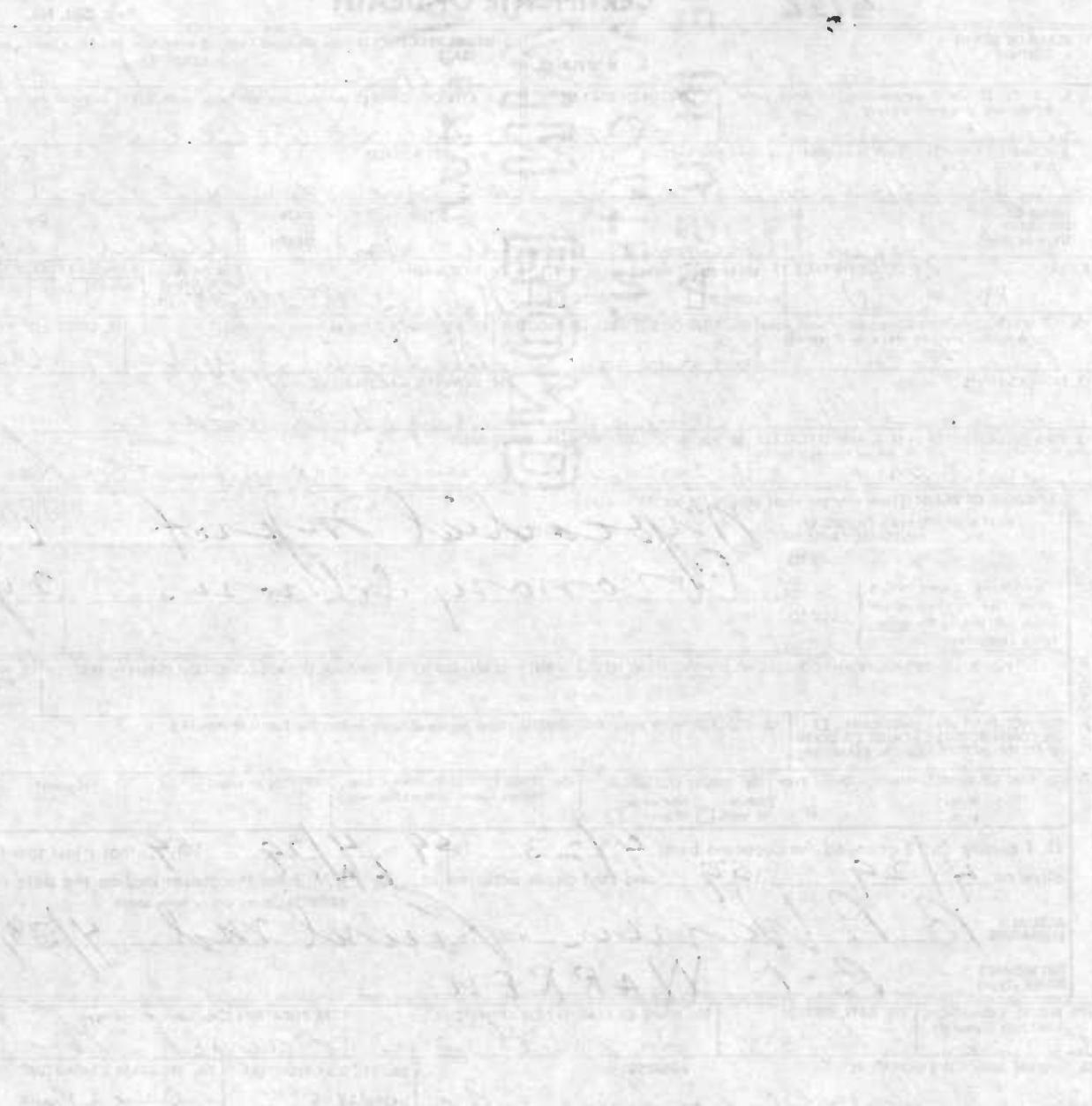
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 04645
Item 9 FilmG242 5-14-59 et 4712 CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY		Princ George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Md.		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Rural - Laurel		22 years		Rural - Laurel						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sandy Spring Road		d. STREET ADDRESS Sandy Spring Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) John Edward Castle Sr.		First	Middle	Last	4. DATE OF DEATH April 29 1959	Month	Day	Year		
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10 1892		9. AGE (In years lost birthday) 66 6/11 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME Emanuel Martin Castle		14. MOTHER'S MAIDEN NAME Elizabeth Bane								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 212-32-6508		17. INFORMANT Mrs Emanuel Castle, Laurel Md Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH 6 hours				
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary Sclerosis		2 yrs				
		DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 4/23, 1959, to 4/29, 1959, that I last saw the deceased alive on 4/29, 1959, and that death occurred at 6 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE B. P. Warren M.D. ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 4/30/59										
PHYSICIAN'S NAME (Type) B. P. WARREN										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/59		22c. NAME OF CEMETERY OR CREMATORIAL Tomy Hill Cem		22d. LOCATION (City, town, or county) Laurel, Md (State)				
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Randolph Laurel, Md		ADDRESS		24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur & Krause				

81. 3900 FT. - HILL TO TOWER IS THE OUTLINE

OF A CITY OR TOWN



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G241, 4/14/59 fcy

CERTIFICATE OF DEATH

04646

Reg. Dist. No.

4662

1. PLACE OF DEATH

o. COUNTY

Prince George,

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

D.O.A.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Murdirk

Murdirk

d. STREET ADDRESS

6100 Murdirk Rd

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

Female

Colored

WIDOWED DIVORCED

Nov 28, 1882

776 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isral Crump

14. MOTHER'S MAIDEN NAME

Elizabeth Swale

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Brother

Address

Irsal Crump Jr. 6118 Murdirk Rd, Murdirk, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cerebrovascular Accident

INTERVAL BETWEEN
ONSET AND DEATH

2 days.

Generalized arteriosclerosis

3 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.20d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 1958 to April 4, 1959, that I last saw the deceased alive on April 2, 1959, and that death occurred at 10:55 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Thomas R. Mazzocco M.D. 320 Montgomery, Laurel, Md 4959

PHYSICIAN'S
NAME (Type)

Thomas R. Mazzocco

22a. BURIAL CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

4-8-59

Queens Chapel cem.

Murdirk, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Henry S Washington - 467-77 St NW

DATE APR 9 '59

Arthur S. Thane

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04647

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		4663		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY		Prince Georges MARYLAND		b. STATE Maryland		c. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cheverly		D.O.A.		33		Bladensburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince Georges General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince Georges General Hospital				5417 McBeth Street		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Susan	Middle May	Collins		4. DATE OF DEATH	Month April	Day 7,	Year 19 59
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years from birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 6, 1880		79 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired		Dressmaker		Georgia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Joseph Kirbo		Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		(If yes, give war or dates of service)		Charles B. Collins; same address as #2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH									
442X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
Hypertension, diabetes.									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED							
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22o. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 4/9/59		22c. NAME OF CEMETERY OR CREMATORIAL Atlanta		22d. LOCATION (City, town, or county) Georgia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 10 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

—MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MASSACHUSETTS STATE MEDICAL EXAMINER'S OFFICE

[View more extensions](#)

General References

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4649

04648

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2901 Arundel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Eleanor	Middle Evelyn	Last Crouch
4. DATE OF DEATH	Month April	Month 25	Day Year 19 59
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-75
9. AGE (in years from birthday) 83 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Thomas Padgett		
14. MOTHER'S MAIDEN NAME Mary Rockett	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO.	17. INFORMANT Hattie P. Crouch; same address as # 2.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cardiovascular renal disease INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUE TO _____ DUE TO _____ DUE TO _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 25, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.	22b. DATE THEREOF 4/28/59	22c. NAME OF CEMETERY OR CREMATORIAL Congressional	22d. LOCATION (City, town, or county) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Mt. Rainier Inc.</i>	ADDRESS md.	24a. REC'D BY REGISTRAR APR 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Tamm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04649

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

4713

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN lb Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Junction of 301 and 50				d. STREET ADDRESS Route # 450		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard		First Boyd	Middle Dale	Lost	4. DATE OF DEATH April 18	Month 18	Doy Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 5, 1938	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Skilled		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theodore Dale				14. MOTHER'S MAIDEN NAME Carrie Viola Mann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. 219-26-3729		17. INFORMANT Personal Papers On body		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed skull DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Occupant of an automobile that was in a collision with another/							
20c. TIME OF INJURY Hour 6:10 P.M.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Place of death		20f. (City or town) Mitchellville P. G.	(County) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 18, 1959			
22a. BURIAL, CREMATION, ETC. (Specify) Burial		22b. DATE THEREOF April 21/59		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Horan	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4714

CERTIFICATE OF DEATH

04650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Fort Foote)</i>		c. LENGTH OF STAY IN 1b <i>7 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Fort Foote, Md.)</i>		d. STREET ADDRESS <i>7823 Fort Foote Rd S.E.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7823 Fort Foote Rd S.E.</i>				d. STREET ADDRESS <i>7823 Fort Foote Rd S.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Davis</i>		First	Middle	Last	4. DATE OF DEATH <i>April 27</i>	Month	Day	Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1865</i>	9. AGE (In years last birthday) <i>94</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Georgetown, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>FRANK Schaefer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth</i>							
15. WAS EVER SERVED IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT <i>Mary Thorne</i>		Address <i>7823 Fort Foote Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <i>Uremia</i> (c) <i>Senility & Art-Sclerotic Gangrene of feet.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture Left Hip Non-Union 6-6-53</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>6-6-53 to 4-27-1959</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7519 Broadview Rd S.E.</i>		20f. (City or town) <i>Washington D.C.</i>		(County)	(State)
21. I certify that I attended the deceased from <i>6-6-53 to 4-27-1959</i> , that I last saw the deceased alive on <i>4-27-1959</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Anna Coyne Todd M.D.</i>		ADDRESS (Street, city or town, state) <i>7519 Broadview Rd S.E.</i>		DATE SIGNED <i>4/27/59</i>					
PHYSICIAN'S NAME (Type) <i>ANNA COYNE TODD</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 29-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sennott Bros</i>		ADDRESS <i>1661 Good Hope Rd</i>		24a. REC'D BY REGISTRAR DATE <i>APR 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			
Death 20 Dec.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4664 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04651
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5436 McBeth Street		e. STREET ADDRESS 5436 McBeth Street	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ethel Lucy Dawson		First	Middle
4. DATE OF DEATH April 14 1959		Month	Day
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-3-1896		9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Press	
14. MOTHER'S MAIDEN NAME Gertrude Drake		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Kenneth A. Browning; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) [b], <u>slowing the underlying cause last.</u> DUE TO (c)		Coronary thrombosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 4/16/59	
22c. NAME OF CEMETERY OR CREMATORIAL Shinglehouse		22d. LOCATION (City, town, or county) Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	

STATE OF MICHIGAN
DEPARTMENT OF STATE - DIVISION OF ELECTIONS
MICHIGAN EXAMINER OF ELECTIONS

STATE OF
MICHIGAN

REGISTRATION
DIVISION

REGISTRATION

REGISTRATION

REGISTRATION

REGISTRATION

REGISTRATION

I am a registered voter in Michigan.

I am a registered voter in another state.

I am a registered voter in another country.

I am a registered voter in Michigan.

I am a registered voter in another state.

I am a registered voter in Michigan.

I am a registered voter in another state.

I am a registered voter in another country.

I am a registered voter in Michigan.

I am a registered voter in another state.

I am a registered voter in another country.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04652

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial affidavit. Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince Georges MARYLAND		a. STATE Maryland b. COUNTY Prince George-	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Ritchie		39 years	
d. LENGTH OF STAY IN lb		X Ritchie	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
7000 White House Rd SE		17000 White House Rd	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Virgil		Cleveland	Dixon
4. DATE OF DEATH		Month	Day
Oct 1, 1884		April	4
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 1, 1884
9. AGE (In years from birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
74 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Farmer		Gardener	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Benjamin Dixon		Susan Phipps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
None		188-38-5069 Mrs. Mandie Dixon, Danvers ✓	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute congestive heart failure	
442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cardiovascular renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		Apr 4, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		4/8/59	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
Cedar Hill		Glendale Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
W.W. Chambers Co. Inc.		517 11th St. E	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
APR 7 '59		John S. K.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4665

CERTIFICATE OF DEATH

04653

Reg. Dist. No.

1. PLACE OF DEATH County Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Forestville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 3401 Boones Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle ANN	Last Donaldson	4. DATE OF DEATH	Month April	Doy 18	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27-1894	9. AGE (in years lost birthday) yrs. 65	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Donaldson				14. MOTHER'S MAIDEN NAME Clara B. Donaldson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Patricia Sears, 3401 Boones Lane, S.E. D. C.		Address Washington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Thromboes, Left mid Cerebral Artery, 6 Day Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO arterio Sclerosis, Cerebral Arteries 1 year (c) Hypertension - arteriosclerosis, HEART 1 year							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from april 18 1959 to Apr 18 1959 , and that I last saw the deceased alive on april 18 1959 , and that death occurred at 2:40P M , from the causes and on the date stated above.		ACTUAL SIGNATURE Samuel J. Sugar		M.D.		ADDRESS (Street, city or town, state) 4300 RAYWOOD Drive MT RAINIER, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-1959		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.		22d. LOCATION (City, town, or county) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Clarkuslo		ADDRESS 517 11st S.E. D.C.		24a. REC'D BY REGISTRAR Arthur & Thorne		24b. REGISTRAR'S SIGNATURE	
				DATE APR 21 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4666

CERTIFICATE OF DEATH

Reg. Dist. No. 04654

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

077

3. NAME OF DECEASED (Type or print)	First George	Middle Milton	Last Dotson	4. DATE OF DEATH April 2 19 59
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5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1881	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Doyys Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME George M. Dotson	14. MOTHER'S MAIDEN NAME Jane Gray
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Margaret E. Dotson, Westwood, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CONGESTIVE HT FAILURE ARTERIOSCLEROTIC HT DISEASE	INTERVAL BETWEEN ONSET AND DEATH 10 days
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
			(State)

21. I certify that I attended the deceased from 7/2 1957, to 4/2 1959, that I last saw the deceased alive on 4/2 1959, and that death occurred at 6:30A.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) 3404 Westwood Ave	DATE SIGNED
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ACTUAL SIGNATURE <i>John Kebre</i>	PHYSICIAN'S NAME (Type) <i>John Kebre M.D.</i>
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22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial 4/5/59	22b. NAME OF CEMETERY OR CREMATORIUM St. Thomas	22d. LOCATION (City, town, or county) Aguasco Md.
(State)	(State)	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 7 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne

WISCONSIN STATE DEPARTMENT OF HIGHLIGHTS - APRIL 1965

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE AT DEATH	CAUSE OF DEATH
John Doe	55 years	Cardiac arrest
DEATH CERTIFIED BY		
Dr. John Smith, M.D.		
APPROVED AND SIGNED		
John Doe, M.D.		
APPROVED AND SIGNED		
John Doe, M.D.		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4638

CERTIFICATE OF DEATH

04655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE			
<i>Prince Georges</i> MARYLAND		<i>Maryland Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b <i>College Park</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9507-50th Place</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	d. STREET ADDRESS <i>9507-50th Place</i>			
3. NAME OF DECEASED (Type or print) <i>Maudie</i>	First <i>Fox</i>	Middle <i>Dream</i>	4. DATE OF DEATH <i>4-18-1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/7/1887</i>		
9. AGE (In years last birthday) <i>92</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	11. BIRTHPLACE (State or foreign country) <i>Tulaski, Tenn.</i>	12. IF UNDER 1 YEAR Months <i>4</i> Days <i>18</i> Hours <i>0</i> Min. <i>0</i>		
13. FATHER'S NAME <i>Billie Daniels</i>	14. MOTHER'S MAIDEN NAME <i>Mary Lee Williams</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>096-9</i>	17. INFORMANT <i>Mabel C. Holloway</i>	Address <i>above</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>			
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>					
(b) <i>Acute Virus Infection</i>		1 mo.			
DUE TO <i>Coronary Heart Disease</i>		1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Sedentary</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Henryville, Tenn.</i>	(County) <i>Henry Co.</i>	(State) <i>Tenn.</i>
21. I certify that I attended the deceased from <i>May 18, 1959</i> , to <i>May 17, 1959</i> , that I last saw the deceased alive on <i>April 18, 1959</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>900 W. 41st St., Henryville, Tenn.</i>		DATE SIGNED <i>17 Apr 1959</i>		
ACTUAL SIGNATURE <i>E. Osmun Barr M.D.</i>					
PHYSICIAN'S NAME (Type) <i>E. Osmun Barr M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/20/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Henryville, Tenn.</i>	22d. LOCATION (City, town, or county) <i>Henryville, Tenn.</i>	(State) <i>Tenn.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Md.</i>	ADDRESS <i>Mt. Rainier</i>	24a. REC'D BY REGISTRAR <i>Arthur & Thora</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Thora</i>		
Date APR 21 '59					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. GEORGE'S-ON-THE-SEA AND THE BAY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04656

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB., Wash 25 DC		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 1697 31st Street NW		g. STREET ADDRESS 47X-3	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Betty	Middle Elaine	Last Dunn
4. DATE OF DEATH	Month April	Day 21	Year 1959
5. SEX	6. COLOR OR RACE Female Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 5, 1923
9. AGE (In years from birthday) 35 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hrs. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sheryl I. Blake		14. MOTHER'S MAIDEN NAME Mabel Lee Scrutchfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 499165386	
17. INFORMANT Address		William E. Dunn 1697 31st St., Washington 7, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.9		INTERVAL BETWEEN ONSET AND DEATH 10 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Glioblastoma multiform 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14, 1959 , to April 21, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 10:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hospital Andrews DATE SIGNED April 21 1959			
ACTUAL SIGNATURE Sanford L. Billet M.D. PHYSICIAN'S NAME (Type) SANFORD L. BILLET CAPT USAF (MC) ADDRESS Andrews AFB., Washington 25, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/59	
22c. NAME OF CEMETERY OR CREMATORIUM Morrisdale Cemetery		22d. LOCATION (City, town, or county) (State) Morrisdale Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga. Ave. N.W.	
24a. REC'D BY REGISTRAR DATE MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4650

CERTIFICATE OF DEATH

04657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PR. GEO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. RAINIER		c. LENGTH OF STAY IN lb 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4020 - 37 st -		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 MT. RAINIER, MD	
d. STREET ADDRESS 14020 37 st.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Willi Am MIDDLE Penn		4. DATE OF DEATH Month APR. Day 16 Year 1959	
5. SEX M		6. COLOR OR RACE Wh	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jul 25- 1903	
9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm Penn Earnest sr		14. MOTHER'S MAIDEN NAME Emma May Millhiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 17. INFORMANT	
		Casey L. Ernest - Mt Rainier Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH, immediate	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Myocardial Infarct	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary sclerosis	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 23, 1959, to APR 16, 1959, that I last saw the deceased alive on APR 13, 1959, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE John M. Grassgreen M.D. ADDRESS (Street, city or town, state) 3101 ARUNDEL RD. DATE SIGNED 4/16/59			
PHYSICIAN'S NAME (Type) IRVING M. GRASSGREEN		MT. RAINIER, MD.	
22a. BURIAL, CREMATION, OR AMMUTATION (Specify) Burial		22b. DATE THEREOF 4/20/59	
22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR APR 21 '59	
4739 Baltimore Ave. Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Yancey	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04658
Reg. Dist. No.

4641

1. PLACE OF DEATH a. COUNTY	Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Hyattsville 8 years transit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	5411 Sargent Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ernest	Middle William	4. DATE OF DEATH Month April Day 14, Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-96	
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Retired plant accountant Telephone Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ernest Foerster	14. MOTHER'S MAIDEN NAME Marie Loeffler		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO.	17. INFORMANT Helen Foerster; same address as # 2.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 442X DUE TO Pulmonary congestion and edema INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congestive heart failure				
(c) DUE TO Cardiovascular renal disease				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John T. Maloney, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 14, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/59	22c. NAME OF CEMETERY OR CREMATORIAL Parkwood	22d. LOCATION (City, town, or county) Baltimore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur & Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04659

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

4667

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

077

1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE D.C.		b. COUNTY		
Cheverly		2 hrs		Washington		47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Prince Georges General Hospital		1115 50th St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Odell	Lost	4. DATE OF DEATH April	Month 1	Day 19	Year 59
5. SEX Male		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1-25-1921	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
None								
13. FATHER'S NAME Wesley Fox		14. MOTHER'S MAIDEN NAME Janet Fitzgerald						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 242-10-2418		17. INFORMANT Van Fox; 1208 50th St., N.E. Wash. D.C.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X		Hemorrhage and shock						
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Gunshot wound of abdomen						
(b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person.						
20c. TIME OF INJURY 6:15 XX p.m.		Month, Day, Year 4-1- 19 59	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) a home	20f. (City or town) Chapel Oaks, Pr. Geo. Md.	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John T. Maloney</i>		DATE SIGNED						
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Washington		(State) D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE <input checked="" type="checkbox"/> John T. Rhines & Co.		ADDRESS 3015 12th St., N. E.		24a. REC'D BY REGISTRAR APR 6 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>		
VS. A15ME BM 2/57								

Medical Examination Report
Date: 10/10/2012
Time: 10:00 AM
Patient Name: John Doe
Age: 35
Gender: Male
Address: 123 Main Street, Anytown, USA
Phone: (555) 123-4567
Occupation: Software Engineer
Employer: TechCorp
Last Health Checkup: 08/2012
Vaccinations: Up-to-date
Medications: None
Allergies: None
Family History: Father has hypertension
Social History: Non-smoker, non-drinker
Lifestyle: Healthy diet, regular exercise
Physical Exam Findings:
- Blood pressure: 120/80 mmHg
- Heart rate: 60 bpm
- Respiratory rate: 16 breaths/min
- Temperature: 98.6°F
- Weight: 180 lbs
- Height: 5'10"
- Skin: Normal skin texture, no rashes or lesions
- Eye: Eyes clear, no conjunctivitis
- Ear: No discharge from ears
- Nose: No nasal congestion
- Throat: No swollen lymph nodes
- Chest: Lungs clear, no crackles or wheezes
- Abdomen: Soft, no tenderness or masses
- Genitalia: Normal male genitalia
- Rectal: Normal rectal examination
- Neurological: Normal reflexes, no sensory deficits
- Musculoskeletal: No joint pain or swelling
- Psychiatric: No signs of depression or anxiety
- Other: No abnormalities found in other systems

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4668

CERTIFICATE OF DEATH

04660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		d. STREET ADDRESS 3015 Lake Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Clara		First (N.M.N.)	Middle Gagne	Last Gagné	4. DATE OF DEATH Month 4	Month 10	Day 19	Year 59
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/17/79	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Taunton, Mass.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Francis X. Poirier		14. MOTHER'S MAIDEN NAME Rosalie Lemoyne						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Delia A. Donatelli, 3015 Lake Ave., Cheverly, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (g), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1wk.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Colmar Manor, Prince George's Co., Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 1, 1959 to April 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at 8PM M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 6124-41st Ave. Hyattsville, Md.		DATE SIGNED 4/11/59		
ACTUAL SIGNATURE Gordon W. Keller								
PHYSICIAN'S NAME (Type) Gordon W. Keller								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Prince George's Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D. BY REGISTRAR Arthur J. Kelly		24b. REGISTRAR'S SIGNATURE Arthur J. Kelly		
				DATE 4/14/59				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4669

CERTIFICATE OF DEATH

04661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 20 hours		d. STREET ADDRESS 41 Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Gant	Last T	4. DATE OF DEATH Month April	Day 11	Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb 12 1912	9. AGE (In years lost birthday) yrs. 47	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Howard Co Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME ERNEST GIBSON		14. MOTHER'S MAIDEN NAME Lavinia Matthews		Address Charles Gant 9th St Laurel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No							
16. SOCIAL SECURITY NO.							
17. INFORMANT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 6124-41st Ave Hyattsville		20f. (City or town) (County) (State) 4/11/59	
21. I certify that I attended the deceased from April 10, 1959 , to April 11, 1959 that I last saw the deceased alive on April 11, 1959 , and that death occurred at 9:20 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Gordon W Kelley ADDRESS (Street, city or town, state) M.D. 6124-41st Ave Hyattsville DATE SIGNED 4/11/59							
220. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF April 15/59		22c. NAME OF CEMETERY OR CREMATORIUM Beacons Chapel Anne Arundel Co. Md		22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Ridgely & Kelly Funeral Md		24e. REC'D BY REGISTRAR DATE APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4670

CERTIFICATE OF DEATH

04662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS / 5022 56th Place.	
3. NAME OF DECEASED (Type or print) Baby Boy		First Middle Last Gardner	4. DATE OF DEATH Month Day Year April 23 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 21 April 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T Gardner		14. MOTHER'S MAIDEN NAME JoAnn Higgins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respir Trm. atletas</i> <i>762.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/12</i> , 19 <i>59</i> to <i>2/12</i> , 19 <i>59</i> that I last saw the deceased alive on <i>2/12</i> , 19 <i>59</i> , and that death occurred at <i>2,15A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Kehoe M.D.</i>			
PHYSICIAN'S NAME (Type) Dr. John Kehoe M.D.		ADDRESS (Street, city or town, state) <i>Chesapeake Md.</i> DATE SIGNED <i>John Kehoe M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/59x	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE APR 29 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

HAWAIIAN STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

5

JULY

2000

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4671

CERTIFICATE OF DEATH

04663

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the death transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural / George Cheverly		c. LENGTH OF STAY IN lb		d. STREET ADDRESS 1733 Keokee Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. DATE OF DEATH Apr. 14		Month	Day	Year
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1917		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10b. KIND OF BUSINESS OR INDUSTRY Printer		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles R. Garwood		14. MOTHER'S MAIDEN NAME Orpha Spoor						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 313-10-9897		17. INFORMANT Grizzelle R. Garwood (Wife)		Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Myocardial infarction.		INTERVAL BETWEEN ONSET AND DEATH 15 min.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Atherosclerosis				3 years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Colmar Manor		20f. (City or town) Colmar	(County) Montgomery	(State) Md.
21. I certify that I attended the deceased from June 8, 1957 , to 7/14 , 1957, that I last saw the deceased alive on 7/14 , 1957, and that death occurred at 10:10 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE F. E. Musser		M.D.		ADDRESS (Street, city or town, state) 4410 74th Ave		DATE, SIGNED 7/14/57		
PHYSICIAN'S NAME (Type) F. E. Musser, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 15 '59		24b. REGISTRAR'S SIGNATURE Arthur & Knudt		

ST-398M128-100A30 TO THE UNITED STATES AND CANADA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04664

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. 1515ME
5M 2/57

4672

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS X Rogers Heights- Hyattsville	
f. FIRST MIDDLE LAST Edward Arthur Givens		g. DATE OF DEATH Month April Day 25 Year 1959	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edward	Middle Arthur	Last Givens
4. SEX Male	5. COLOR OR RACE white	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH 12-4-92
8. AGE (In years last birthday) 66 yrs.	9. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	10. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer		10b. KIND OF BUSINESS OR INDUSTRY Iron Co.	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Givens		14. MOTHER'S MAIDEN NAME Malinda Durham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Jack A. Givens; Riverdale, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. Coronary thrombosis DUE TO Cardiovascular renal disease	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 25, 1959
EXAMINER'S NAME (Type) John T. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/59	22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	22d. LOCATION (City, town, or county) Colmar Manor (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Avenue Hyattsville, Maryland	24a. REC'D BY REGISTRAR DATE APR 27 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur & Hansen</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4717

CERTIFICATE OF DEATH

04665

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Pr Geos Co</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>	b. COUNTY <i>Pr. Geos Co</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seat Pleasant</i>	c. LENGTH OF STAY IN 1b <i>42</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Seat Pleasant Md.</i>	d. STREET ADDRESS <i>606 - 62 na Place</i>					
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <i>606 - 62 na Place -</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mildred Adeline Godfrey</i>	First	Middle	Last	4. DATE OF DEATH <i>April 22 1959</i>	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 5 1896</i>	9. AGE (In years lost birthday) <i>63 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>					
13. FATHER'S NAME <i>Lewis Seltzer</i>	14. MOTHER'S MAIDEN NAME <i>Lenora Facer</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mildred Armstrong - 606-62 na Seat Pleasant</i>	Address <i>Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 Hours</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> (c) <i>Generalized Arteriosclerosis</i>			10 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>							
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>May 13, 1949</i> , to <i>April 22, 1959</i> , that I last saw the deceased alive on <i>April 21, 1959</i> , and that death occurred at <i>5:00 AM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>W. Suit Ritchie</i>	ADDRESS (Street, city or town, state) <i>7005 Ritchie Road SE (4/22/59)</i>	DATE SIGNED <i>4/22/59</i>						
PHYSICIAN'S NAME (Type) <i>W. Suit Ritchie M.D.</i>	Wash 27 D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/25/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Suitland</i>	(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>	4739 Baltimore Ave. Hyattsville, Md.	24a. REC'D BY REGISTRAR <i>Arthur L. Krause</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>	DATE APR 24 '59				

2000

STATE OF HAWAII - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME

NAME

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ADDRESS

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AGE

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SEX

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MARITAL STATUS

MARITAL STATUS

MARITAL STATUS

MARITAL STATUS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4718

CERTIFICATE OF DEATH

04666
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Prince George MARYLAND		Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights		c. LENGTH OF STAY IN 1b 8 mos.	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION None		e. STREET ADDRESS 16467-K St. NE	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month April Day 16 Year 1959	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/1874	
WIDOWED <input checked="" type="checkbox"/>		9. AGE (In years last birthday) 83 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10. MIND OF BUSINESS OR INDUSTRY Residence	
11. BIRTHPLACE (State or foreign country) DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Alice Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. Mrs. Mary Alice Smith	
(Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Acute congestive heart failure 2 wks.	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO Arteriosclerotic heart dis?	
{ (c)		DUE TO Generalized arteriosclerosis?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerotic dementia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10, 1958, to April 16, 1959, that I last saw the deceased alive on April 16, 1959, and that death occurred at 6 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Robert Nelson M.D. ADDRESS (Street, city or town, state) Physician's Name (Type) Robert R. NELSON Washington, D.C. DATE SIGNED 4/16/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-59	
22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros, 621 Fl. am NW		ADDRESS	
		24a. REC'D BY REGISTRAR APR 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Sharpe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04667

Reg. Dist. No.

1		4719		CERTIFICATE OF DEATH			
M							
C							
I							
2							
VS A15 (4) 15M 9/55							
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.							
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.							
1. PLACE OF DEATH a. COUNTY		Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE None		b. COUNTY None	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 25, DC		c. LENGTH OF STAY IN lb 10 Hrs 55 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) None		d. STREET ADDRESS Washington 20, D. C. 4719-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS None 3353 - 23rd St., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Kevin Middle --- Last Hayes		4. DATE OF DEATH April		Month 16	Day 19 Year 59
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16 1959	
9. AGE (In years (last birthday)) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. KIND OF BUSINESS OR INDUSTRY None		12. BIRTHPLACE (State or foreign country) Maryland	
13. CITIZEN OF WHAT COUNTRY? USA		14. FATHER'S NAME William Rogers Hayes		15. MOTHER'S MAIDEN NAME Louise Reed			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None		18. INFORMANT Father		Address 3353 23rd Street SE Washington 20, DC	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. MEDICAL CERTIFICATION		21. I certify that I attended the deceased from April 16, 1959, to April 16, 1959, that I last saw the deceased alive on April 16, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Douglas E. Pierce M.D. ADDRESS (Street, city or town, state) DOUGLAS E. PIERCE CAPT USAF (MC) Andrews AFB., Washington 25, DC DATE SIGNED 16 Apr 59		INTERVAL BETWEEN ONSET AND DEATH 10 Hrs 55 Min	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/13/59		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		ADDRESS 4804 Ga. Ave.		24a. REC'D BY REGISTRAR Arthur S. Thomas		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
2050212X2				DATE APR 24 '59			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4720

CERTIFICATE OF DEATH

04668

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROOM	c. LENGTH OF STAY IN lb 24 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CROOM	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION STAR ROUTE BOX 40 UPPER MARLBORO MD		d. STREET ADDRESS STAR ROUTE BOX 40 UPPER MARLBORO	
3. NAME OF DECEASED (Type or print) DANIEL HENSON		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4. SEX M	5. COLOR OR RACE N	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH AUG 12 1781
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM HENSON		14. MOTHER'S MAIDEN NAME ADELICE HENSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. ?	
17. INFORMANT ELLEN VICTORIA HENSON (wife)		9. AGE (In years lost birthday) 77 yrs.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) INANITION		10. IF UNDER 1 YEAR Address Months Days Hours Min. 8 MONTHS 27 00 00 INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 8, 1959, to APRIL 8, 1959, that I last saw the deceased alive on APRIL 8, 1959, and that death occurred at 12 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Everett W. Cadenhead, M.D. ADDRESS (Street, city or town, state) 3904 Eln St. DATE SIGNED			
PHYSICIAN'S NAME (Type) EVERETT W. CADENHEAD JR. UPPER MARLBORO MARYLAND			
22a. BURIAL CREMATION, REMOVAL (Specify) #18-59		22b. DATE THEREOF 4-18-59	
22c. NAME OF CEMETERY OR CREMATORIAL CHAPEL St. John's Episcopal Chapel		22d. LOCATION (City, town, or county) Croom Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons		ADDRESS 467-71-St. St. 16	
24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thorne	

U.S. GOVERNMENT PRINTING OFFICE: 1934 10-1400

CERTIFICATE OF
REGISTRATION

THE ESTATE OF
JOHN D. ROCKEFELLER,
JR.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 241 4-22-59 ams

4673

CERTIFICATE OF DEATH

04669

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		CERTIFICATE OF DEATH									
		4673									
2		1. PLACE OF DEATH a. COUNTY Prince Georges County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY PG			
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b RURAL and give nearest town) 2 Hr 10 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, MD		d. STREET ADDRESS 14708 66th Place			
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
		3. NAME OF DECEASED (Type or print) Michael		First	Middle	Last	4. DATE OF DEATH Jacobs	Month	Day	Year	
		5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/58	9. AGE (In years last birthday) 1 yr.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
		13. FATHER'S NAME Jack Leroy Jacobs		14. MOTHER'S MAIDEN NAME Barbara Overstreet		Address					
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Jack L. Jacobs (father)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) No accident or injury involved							
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) No accident or injury involved		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
		21. I certify that I attended the deceased from <u>April 8, 1959</u> , to <u>April 9, 1959</u> , that I last saw the deceased alive on <u>April 9, 1959</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE Dr. John Perkins		ADDRESS (Street, city or town, state) M.D. 5301 Hamlin St., Hyattsville, MD 4/10/59			DATE SIGNED 4/10/59				
		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 13, 1959		22c. NAME OF CEMETERY OR CREMATORIUM National Memorial Park		22d. LOCATION (City, town, or county) Falls Church, Virginia (State)			
		23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.		ADDRESS Va.		24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Mann			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4642

CERTIFICATE OF DEATH

04670

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hawthorne Md.</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>8 yrs.</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <i>Hawthorne Convalescent & Rest Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Henry James</i>		First <i>Jahn</i>	Middle <i>Henry</i>
4. DATE OF DEATH <i>April 12 1959</i>		Lost <i></i>	Month <i></i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 15 1872</i>
9. AGE (In years last birthday) <i>86 yrs.</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>27</i>	11. IF UNDER 24 HRS. Hours <i>8</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook man-Navy Yd.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
10c. BIRTHPLACE (State or foreign country) <i>Sharpsburg- Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John S. James</i>		14. MOTHER'S MAIDEN NAME <i>Indiana V. Malone</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes Spanish War</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. Agatha Murray (sister)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC FAILURE</i> DUE TO <i>450.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>GENERALIZED ARTERIOSCLEROSIS</i> DUE TO (c) <i></i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>CEREBRAL ARTERIOSCLEROSIS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12 APRIL 1959</i> , to <i>SAME</i> , that I last saw the deceased alive on <i>12 APRIL 1959</i> , and that death occurred at <i>105 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry R. Wolfe</i>		ADDRESS (Street, city or town, state) <i>905 SHERIDAN ST HAWTHORNE MD.</i> DATE SIGNED <i>4/14/59</i>	
22a. BURIAL, CREMATION, BURIAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/15/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Boonsboro Gem.</i>		22d. LOCATION (City, town, or county) <i>Boonsboro, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 14 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Philip		First	Middle	Lost	4. DATE OF DEATH April 21	Month	Doy	Year
5. SEX Male		6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR yrs. Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME John Jenifer		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<i>Congestive ht failure</i>		<i>Abercrombie ht. disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 wks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4/1 , 19 59 , to 4/21 , 19 59 that I last saw the deceased alive on 4/20 , 19 59 , and that death occurred at 1:35 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Kehoe</i>						ADDRESS (Street, city or town, state) Hyattsville Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-25-59		22b. DATE THEREOF 4-25-59		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys County		22d. LOCATION (City, town, or county) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Frazor Funeral Home		ADDRESS 389-R.T. Ave. N.W.		24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thorne		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04672

Reg. Dist. No.

CERTIFICATE OF DEATH

4675

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	c. LENGTH OF STAY IN lb 2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4806 Rittenhouse Street	d. STREET ADDRESS 4806 Rittenhouse		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First MABEL	Middle BELL	Last JONES
4. DATE OF DEATH April 13th, 1959	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 10th, 1882
9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Turner		14. MOTHER'S MAIDEN NAME Alice Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-34-4349B 17. INFORMANT Willard E. Jones, 4806 Rittenhouse St. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
442 X Conditions, if any, which gave rise to immediate cause (a), stating the under: lying cause lost.		DUE TO (b) Hyperkinetic cardio vascular (c) renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-10-59, 19, to 4-13-59, 19, that I last saw the deceased alive on 4-13-59, 19, and that death occurred at 6:15A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John P. Clum</i>		ADDRESS (Street, city or town, state) M.D. 6110-43rd Ave., Hyattsville, Md. DATE SIGNED 4/13/1959	
PHYSICIAN'S NAME (Type) JOHN P. CLUM			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'l Cem.		22d. LOCATION (City, town, or county) Suitland, Pr. Geo. Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR APR 17 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Cirthur S. Traut</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4643

CERTIFICATE OF DEATH

04673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> (WASHINGTON D.C.)		Mont.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>(16)</i>		(15x-2)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll MANOR</i>		d. STREET ADDRESS <i>5319 YORKTOWN Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>DR. Thomas Glenn Jones</i>		First	Middle	Last	4. DATE OF DEATH <i>April 28 1959</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-1875</i>		9. AGE (In years lost birthday) <i>83 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min. <i>7 17</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MEDICAL Doctor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PHYSICIAN</i>		11. BIRTHPLACE (State or foreign country) <i>Washington DC.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas Glenn Jones</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth King</i>		Address <i>51 Maureen Therese - Carroll</i>		<i>MARY</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>095-09-4451A</i>		17. INFORMANT <i>Sr. Maureen Therese - Carroll</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first.</i>		ARTERIOSCLEROTIC HEART DISEASE				
(b) DUE TO <i>Myocardial Infarction</i>		(c) DUE TO <i>ARTERIOSCLEROTIC HEART DISEASE 5 years</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>2-17</i> , 19 <i>58</i> , to <i>4-38</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4-87</i> , 19 <i>59</i> , and that death occurred at <i>11 30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>332 - K ST NE</i>		DATE SIGNED <i>4-88-59</i>				
ACTUAL SIGNATURE <i>Thomas F Collins</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>THOMAS F COLLINS</i>		WASH DC						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 1959</i>		22b. DATE THEREOF <i>1959-1-1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. Gaffell</i>		ADDRESS <i>475-H-78 dash</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG241 4-27-59 et

04674

Reg. Dist. No.

4676

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 4503 24th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Takechiyo		Middle Katsu		4. DATE OF DEATH April 22		Month	Doy	Year	
S. SEX Female	6. COLOR OR RACE Oriental	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/24/1894	9. AGE (In years lost birthday) 65	yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? Japan			
13. FATHER'S NAME ---Nobutada				14. MOTHER'S MAIDEN NAME unobtainable					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address John Katsu-4503-24th Ave. Avondale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO THROMBOSIS, RT. MID. CEREBRAL ARTERY 5 DAYS ARTERIOSCLEROSIS, CEREBRAL ARTERIES 1 YEAR									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from JAN 1, 1958 to APRIL 22, 1959 , that I last saw the deceased alive on APRIL 22, 1959 , and that death occurred at 4:05A M , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) MT. RAINIER, Md. aferry's									
DATE SIGNED									
ACTUAL SIGNATURE Samuel J. Sugar									
PHYSICIAN'S NAME (Type) Dr. Sam Sugar, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 25, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) Prince Georges Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. J. Hines Co.		ADDRESS 2901-14th St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

STATE OF CALIFORNIA - DIVISION OF MOTOR VEHICLES

CERTIFICATE OF REGISTRATION

2513

80 E 789

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4721

CERTIFICATE OF DEATH

04675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 5 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 3 Box 31		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AURA LEONA LAKEMAN		4. DATE OF DEATH APRIL 19 1959	Month Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 28, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		11b. KIND OF BUSINESS OR INDUSTRY J.C. PENNEY	
11c. BIRTHPLACE (State or foreign country) NEW HAMPSHIRE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SETH QUINBY		14. MOTHER'S MAIDEN NAME AURA ANNEDOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 001-01-6856	
17. INFORMANT LOUISE MARION ROSENTHAL		Address RT 3 Box 31 CLINTON MD. DAUGHTER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETIC-ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 PREVIOUS MYOCARDIAL INFARCTS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 1959		20d. INJURY OCCURRED While at work Not while at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT 9, 1958 to PRESENT, that I last saw the deceased alive on MAR. 25, 1959, and that death occurred at 5:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Arthur Shaver Jr. M.D. ADDRESS (Street, city or town, state) DATE SIGNED Branch Ave.-Clinton, Md. Apr 19, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-59	
22c. NAME OF CEMETERY OR CREMATORIAL BLOSSOM HILL		22d. LOCATION (City, town, or county) Concord New Hampshire (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR ADDRESS 1661-Good Hope Rd SE DATE APR 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur Shaver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF HAWAII - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

TELEGRAMS

FAX

E-MAIL

TELETYPE

DEATH CERTIFICATE NUMBER

DEATH DATE

DEATH PLACE

DEATH TIME

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04676

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used only for burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7508 Hawthorne Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Ann Land		First Margaret	Middle Ann
4. DATE OF DEATH April 6 1959		Lost	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 2, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kenneth Alfred Land		14. MOTHER'S MÄDEN NAME Margaret Ann Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Thomas W. Scott; 3704 40th Avenue Cottage City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John J. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 7. 1959.
EXAMINER'S NAME (Type) John T. Maloney, M.D.	22b. DATE THEREOF 4/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22d. LOCATION (City, town, or county) Washington D. C.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR DATE APR 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Poole

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G241 5-1-59 et

04677

4677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Prince George MARYLAND		Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ELAND MEMORIAL		d. STREET ADDRESS 14704 Garret Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First William P Lankford		4. DATE OF DEATH Month April Day 24 Year 1959	
3. NAME OF DECEASED First William P Lankford		4. DATE OF DEATH Month April Day 24 Year 1959	
5. SEX m 6. COLOR OR RACE wh		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 10-21-96		9. AGE (In years lost birthday) 62 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY US			
13. FATHER'S NAME William LANKFORD		14. MOTHER'S MAIDEN NAME MARLOWE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT William LANKFORD - Son Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis 1 day Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary Atherosclerosis 6 yrs (c) DUE TO Arteriosclerosis 6 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pylonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/16/55 to 4/24/59, that I last saw the deceased alive on 4/17/55, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE J M Warren M.D. DATE SIGNED 4/24/59		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-28-59		22b. DATE THEREOF 4-28-59	
22c. NAME OF CEMETERY OR CREMATORIALawn on		22d. LOCATION (City, town, or county) Baltimore MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR APR 28 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & Kline	

DEPARTMENT OF STATE DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04678
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale, Hyattsville			c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale, Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2201 Beechwood Road			d. STREET ADDRESS 2201 Beechwood Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Frank	Middle William	Last Lee	4. DATE OF DEATH April 13 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1883	9. AGE (In years less than 75 day) 75 yrs.	IF UNDER 1YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker	10b. KIND OF BUSINESS OR INDUSTRY City Bank Vice-President	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Francis Lee	14. MOTHER'S MAIDEN NAME Isabelle ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 577-10-2322	17. INFORMANT Records at City Bank, Wash.D.C.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to underlying cause (b), stating the cause lost. (c) Cardiovascular renal disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED April 13, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.	22b. DATE THEREOF 4/16/1959	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.	ADDRESS 2901 14th St. N.W. Washington 9, D.C.	24a. REC'D BY REGISTRAR APR 15 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

MANUFACTURERS SIZE DESIGNATION OF HEAVY-SAILED HOME'S
FOR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

U.S. STATE
PRINTING OFFICE



1757

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04679
Reg. Dist. No.

4678

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b B.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 31 Avondale Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Harry	Middle Gilmore	Last Leishure	4. DATE OF DEATH April 14, 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-07	9. AGE (in years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY State Roads		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Morris Leishure		14. MOTHER'S MAIDEN NAME Helen Lottie Wells		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Goldie Leishure; same address as # 2.	
No					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 14, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-59	22c. NAME OF CEMETERY OR CREMATORIAL Ivy Hill	22d. LOCATION (City, town, or county) (State) Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby, 1200 Snowden Place, Laurel, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Tracy	

RE: 350MMI20-132734 RO 350MMI20 STATE 00A13200
HEAT TO 842°F 332°C 100% MAX TA 1000°F

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4723

CERTIFICATE OF DEATH

04680
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE District of Columbia b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 25, D. C.		c. LENGTH OF STAY IN lb 2 hrs 12 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		d. STREET ADDRESS 103 Audrey Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Tina	Middle Lee	Lost Lemons	4. DATE OF DEATH April 17 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 5, 1958	9. AGE (In years lost birthday) yrs. 8 12	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 12	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Paul R. Lemons			14. MOTHER'S MAIDEN NAME Clarsie M Cooke					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT 823rd Installation Squadron Father Homestead AFB, Florida				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Meningitis DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH 6 Mos								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from April 17, 1959 to April 17, 1959 , that I last saw the deceased alive on April 17, 1959 , and that death occurred at 7:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Andrews AFB., Washington 25, D. C. DATE SIGNED April 17, 1959								
ACTUAL SIGNATURE John A. Moore M.D. USAF Hospital Andrews								
PHYSICIAN'S NAME (Type) JOHN A. MOORE CAPT USAF (MC) Andrews AFB., Washington 25, D. C.								

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 4/20/59	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home Wash. D.C.		ADDRESS 5103 Wisconsin	24e. REC'D BY REGISTRAR Arthur L. Krause
		DATE APR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 ДРУГИЕ – НАЧАЛОСТЬ ИННОВАЦИОННОГО РАЗВИТИЯ ФИНАНСОВЫХ УСЛУГ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4724

CERTIFICATE OF DEATH

04681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince George MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
PARKLAND AND WASHINGTON		PARKLAND.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Residence		5504 PARKLAND Court	
e. LENGTH OF STAY IN lb		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28 DC			
3. NAME OF DECEASED (Type or print)		First	Middle
Helene		F	Lennon
4. DATE OF DEATH		Month	Day
April 12		Year	1959
5. SEX		6. COLOR OR RACE	
FEMALE		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		9. AGE (In years (last birthday) yrs.)	
DIVORCED <input type="checkbox"/>		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House Wife		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		Washington D.C. U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
GUS W. FOSSBERG		MARGARET STEEP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
None		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) General Arterio Sclerosis		Unknown	
DUE TO			
(c) unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chronic Gastritis entered since Jan 1959			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural causes	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2, 1959, to April 12, 1959, that I last saw the deceased alive on April 10, 1959, and that death occurred at 9 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE Washington 28 DC	
ACTUAL SIGNATURE PAUL C VAN Natta M.D.		DATE SIGNED 1959	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/59	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Swithland MD	
23. FUNERAL DIRECTOR'S SIGNATURE William Lee's Son D.C.		ADDRESS 300-45th St NE REG'D BY REGISTRAR APR 14 '59	
		DATE APR 14 '59	
		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF

CERTIFICATE OF DEATH

See Page 10

Form No. 200

Name of deceased

Name of physician

Name and address of hospital

Name and address of funeral home

Name and address of informant

Name and address of coroner

Name and address of medical examiner

Name and address of pathologist

Name and address of embalmer

Name and address of mortician

Name and address of funeral director

Name and address of funeral parlor

Name and address of cemetery

Name and address of funeral home

Name and address of funeral director

Name and address of funeral parlor

Name and address of cemetery

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Name and address of cemetery

Name and address of funeral home

Name and address of funeral director

Name and address of funeral parlor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04682

Reg. Dist. No.

4679

1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Pr. Geo.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

34 Brentwood

3. NAME OF
DECEASED
(Type or print)

First
James

Middle
Francis

Last
Mack

4. DATE
OF
DEATH
April
13,

Month
1959

Day
Year
13, 1959

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)
31 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

Male

white

WIDOWED DIVORCED

11-2-27

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Electrical

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James F. Mack

14. MOTHER'S MAIDEN NAME

Lida Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)

Yes

W.W.2

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Barbara Yates; 4704 Eades St., Rockville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemorrhage and shock

INTERVAL BETWEEN
ONSET AND DEATH

976X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), slotting the underlying
cause last.

Cerebral laceration

DUE TO

(b)

(c)

Gunshot wound of head

16
MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Self inflicted wound of head.

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year

Hour o. m.
2.45 5pm

4-11- 1959

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Brentwood

(County)

(State)

Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

John T. Maloney

DATE SIGNED

EXAMINER'S
NAME (Type)

John T. Maloney, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

April 13, 1959

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
4/17/59

22c. NAME OF CEMETERY OR CREMATORIUM
Greenwood

22d. LOCATION (City, town, or county)
Tuckerton

(State)
N.J.

23. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

4739 Baltimore Ave.
Hyattsville, Md.

24a. REC'D BY REGISTRAR
APR 15 '59

24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus

STATE OF GEORGIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22

11

2011

2011

12

10-2011

12

Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04683

Reg. Dist. No.

4680

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 5312 Chesapeake Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Catherine Matthews		First	Middle	Lost	4. DATE OF DEATH Month April	Month 24	Day 19	Year 59	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10/15/78	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Dots 0 Hours 0 Min. 0			
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME William Robey		14. MOTHER'S MAIDEN NAME Blanch E. ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elizabeth Brooke Daughter		Address Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
<i>Pulmonary embolus left. P. ad</i> <i>Arterio sclerosis w/ disease.</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 24 , 19 59 , to 19 , that I last saw the deceased alive on April 24 , 19 59 , and that death occurred at 8 P.M. M, from the causes and on the date stated above.									ADDRESS (Street, city or town, state) 2513 Bullionge Rd.
ACTUAL SIGNATURE <i>R.D.Bauer</i>		DATE SIGNED 4/25/59							
PHYSICIAN'S NAME (Type) R. D. BAUER									
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. DATE THEREOF 4/28/59		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave, Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 27 59		24b. REGISTRAR'S SIGNATURE Arthur S. Phane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT - ELECTIONS

CERTIFICATE OF DEATH

REGISTRATION NUMBER

REGISTRATION DATE

DEATH DATE

DEATH PLACE

DEATH TIME

DEATH CAUSE

DEATH REASON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4681

CERTIFICATE OF DEATH

Reg. Dist. No. 04684

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 19H 40Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 4310 Jefferson St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Francis B. McAuliffe		First	Middle	Last	4. DATE OF DEATH April 26	Month	Day	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-93	9. AGE (In years from birthday) 66 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? U. S.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food & Drug Inspector		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Randolph, Mass				
13. FATHER'S NAME Robert J. McAuliffe		14. MOTHER'S MAIDEN NAME Margaret McAuliffe						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Agnes McAuliffe Address address above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebrovascular Disease (c) DUE TO Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 17 hr.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Apr. 26		(County) (State)
21. I certify that I attended the deceased from Apr. 25, 1959, to Apr. 26, 1959, that I last saw the deceased alive on Apr. 26, 1959, and that death occurred at 5:00 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Prince Georges General Hospital Cheverly, Md.		DATE SIGNED 4/27/59
ACTUAL SIGNATURE R.D.Bauer, M.D.		M.D.						
PHYSICIAN'S NAME (Type) R.D.Bauer, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/59		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln		22d. LOCATION (City, town, or county) Colmar Manor, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Kalle's Funeral Home, Inc.		ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna		

81 COMMITTEE—IT IS TO THEM THAT STATE OWNED LANDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04685

Reg. Dist. No.

1		4725		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.		o. COUNTY Prince Georges MARYLAND		o. STATE D. C. b. COUNTY —	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 1 yr., 2 months, and 5 days	
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington ✓ 47X.3	
		d. STREET ADDRESS 1316 Corcoran St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Perry	Middle C.	Last Miller	4. DATE OF DEATH 4 5 19 59
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1900	9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Munsey Realtor Co.		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Jesse Miller		14. MOTHER'S MAIDEN NAME Rosetta Johnson		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] —		16. SOCIAL SECURITY NO. 578-12-5396		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 22 months			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1		Bronchogenic carcinoma, right lung, with metastasis to both lungs, liver, & mediastinal lymph nodes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Diabetes mellitus; convulsive disorder, post-traumatic					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on		1/31/1958, to 4/5/1959, that I last saw the deceased			
		and that death occurred at 1:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale Hospital 4/5/59			
22a. BURIAL CREMATION, REMOVAL (Specify) 4/9/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn	
22d. LOCATION (City, town, or county) Washington, D.C. (State)		23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jaynes		24a. REC'D BY REGISTRAR APR 10 '59	
		ADDRESS 116 Mass. Ave. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Thruitt	

OF EQUITIES—THEIR USE IN INVESTMENT PLANNING

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4639

CERTIFICATE OF DEATH

04686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		<i>Beth Geo</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
		MARYLAND		a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY <i>Baltimore</i>	
<i>College Pk</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>4610 Guilford Rd</i>		<i>Same</i>			
3. NAME OF DECEASED (Type or print)		First <i>MARY</i>	Middle <i>AMELIA</i>	Last <i>MORRISON</i>	4. DATE OF DEATH Month <i>APR</i> Day <i>25</i> Year <i>1959</i>
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>17 Dec 1872</i>	9. AGE (In years (or birthday) <i>86 yrs.</i>) IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10d. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Charles Wentz</i>		14. MOTHER'S MAIDEN NAME <i>Beningna Hohn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT George W. Morrison <i>4610 Guilford Rd.</i> College Pk, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>420.0</i>		<i>Deute Bilateral Pulmonary Congestion 30</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first.		DUE TO (b) <i>Arterio-sclerotic Heart Disease</i>	DUE TO (c) <i>Compensation</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>p. m.</i> <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Port Deposit</i>	(County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Dec 1959</i> to <i>Apr 1959</i> , that I last saw the deceased alive on <i>Apr 1959</i> , and that death occurred at <i>12:15 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>4713 Berwyn Blvd</i>			
ACTUAL SIGNATURE <i>W.C. ETIENNE</i>		DATE SIGNED <i>#2559</i>			
PHYSICIAN'S NAME (Type) <i>W.C. ETIENNE</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 27, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Hopewell Cemetery</i>	22d. LOCATION (City, town, or county) <i>Port Deposit, Md.</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leesa Patterson Jones</i>		ADDRESS <i>Perryville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>APR 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

STATE DEPARTMENT OF HEALTH - DISEASES 18
CITY OF CALIFORNIA

1900

1900

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4645

CERTIFICATE OF DEATH

114687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		c. LENGTH OF STAY IN 1b <i>4 yrs.</i>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Nyattsville Convalescent + Rest Home</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>D.C.</i>	
3. NAME OF DECEASED (Type or print)		First <i>Julia</i>	Middle <i>Albertina</i>	Lost <i></i>	4. DATE OF DEATH <i>April 23 1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/15/1879</i>	9. AGE (In years last birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>	
13. FATHER'S NAME <i>Julius E. Juengemann</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Robert C. Beall - 6315 Seabrook Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260 X</i>		<i>Cerebrovascular thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <i>generalized arteriosclerosis</i>			
(c) <i>Diabetes mellitus</i>				1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 1959</i> , to <i>April 1959</i> , that I last saw the deceased alive on <i>April 20, 1959</i> , and that death occurred on <i>April 20, 1959</i> , M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>905 Sheridan St</i>	
ACTUAL SIGNATURE <i>Arnold A. Lear</i>		M.D.		DATE SIGNED <i>4/13/59</i>	
PHYSICIAN'S NAME (Type) <i>ARNOLD A. LEAR</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/27/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>	
22d. LOCATION (City, town, or county) <i>Arlington</i>				(State) <i>Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		4739 Baltimore Ave. Hyattsville, Md.		24a. REG'D BY REGISTRAR <i>APR 27 1959</i>	
				DATE <i></i>	
				24b. REGISTRAR'S SIGNATURE <i>Colleen S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04688

Reg. Dist. No.

4682

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b Dead on arrival X Rosaryville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital	d. STREET ADDRESS Dower House Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

099

3. NAME OF DECEASED (Type or print) William Leonard Newman	First	Middle	Last	4. DATE OF DEATH Month April Day 6 Year 1959
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME William Henry Newman	14. MOTHER'S MAIDEN NAME Elizabeth Ida Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT Joseph M. Newman, Clinton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cardiovascular renal disease		Acute congestive heart failure
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
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ACTUAL SIGNATURE James I. Boyd	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED April 7, 1959
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22a. FUNERAL CREMATION, DATE THEREOF Removal (Specify) Funeral 4/9/59	22b. NAME OF CEMETERY OR CREMATORIAL Rosaryville Catholic	22c. LOCATION (City, town, or county) Rosaryville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Fun. Home, Waldorf, Md.	ADDRESS	24a. REC'D BY REGISTRAR APR 13 '59
24b. REGISTRAR'S SIGNATURE Arlie S. Price		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 2/57

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MEDICAL CERTIFICATION

2

BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

104689
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		d. STREET ADDRESS 5707 Longfellow St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Name: Leonard Last Name: Amos Norton		Last		4. DATE OF DEATH Month April		Day 27	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-75	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. KIND OF BUSINESS OR INDUSTRY with Contractors		12. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME James F. Norton		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-07-8412-4208-34	
17. INFORMANT Edward C. Norton		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/19/59		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 4/27/59 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Max M. Herzberg		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4/19/59		20c. DATE THEREOF 5/1/59		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln	
22d. LOCATION (City, town, or county) Colmar Manor, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Galleys Funeral Home, Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur & Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYOMING STATE DEPARTMENT OF HIGHWAYS - BILLBOARD

CERTIFICATE OF DESIGN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4684

CERTIFICATE OF DEATH

04690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN lb 3 Month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital	d. STREET ADDRESS 5628 Addison Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John	First J. Middle Perry	4. DATE OF DEATH Apr. 3	Month Day Year 19 59
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1933
9. AGE (In years last birthday) 25 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Kitchen of Hosp.	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Foster Perry		
14. MOTHER'S MAIDEN NAME Lillie Harrison	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Mary Brown, Aunt,	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Pulmonary edema Anemia Angioedema Hypertension			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 7, 1959, to Apr. 3, 1959, that I last saw the deceased alive on Apr. 3, 1959, and that death occurred at 8 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R.D.BAKER, M.D.	ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. DATE SIGNED 4/4/59		
PHYSICIAN'S NAME (Type) R.D. BAKER, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4-9-59	22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) 4611 Benning Rd. N.E.
23. FUNERAL DIRECTOR'S SIGNATURE Henry S Washington & Sons	ADDRESS 467-78172	24a. REGD BY REGISTRAR APR 9 59	24b. REGISTRAR'S SIGNATURE Arthur S. Thrua

81 FORTRESS - ESTABLISHED BY THE GOVERNMENT
TO STABILIZE THE COUNTRY

92-2-4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverry		c. LENGTH OF STAY IN lb 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 9220 Defense Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Margaret Catherine		First Margaret	Middle Catherine	Last Peters	4. DATE OF DEATH April 27 1959	Month April	Day 27	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 15 Aug 1884	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Hours	Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Samuel C. Peters, 9220 Defense Hwy. Lanham, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) 434.1		DUE TO Conditions, if any, which gave rise to immediate cause (o.), stating the under- lying cause last. (b)		<i>Pulmonary infarction</i>		INTERVAL BETWEEN ONSET AND DEATH 1 week		
DUE TO (c)		<i>Congestive Heart Failure</i>		2 weeks.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from alive on 4/14/59 , 1959, to 4/17/59 , 1959, and that death occurred at 6:20 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4410 74 Ave, Landover Hill, Md.		DATE SIGNED 8/10/59				
ACTUAL SIGNATURE <i>J. W. Chambers</i>		PHYSICIAN'S NAME (Type) D. Fred. Musser., M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/1959		22c. NAME OF CEMETERY OR CREMATORIUM Washington Nat'L Cemetery		22d. LOCATION (City, town, or county) Suitland Rd. Pr. Geo. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR Arthur & Kraus		24b. REGISTRAR'S SIGNATURE		
				DATE APR 29 '59				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4726

CERTIFICATE OF DEATH

04692
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Prince George's MARYLAND</i>		<i>Maryland Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bradbury Heights</i>		<i>1 year</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>12406 - 53rd Avenue</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Henry Connor Plott</i>		Last	
4. DATE OF DEATH		Month	Day
		4	4
		Year	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>M</i>		<i>W</i>	<i>9/25/1890</i>
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
		<i>68</i>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Petrol 17a drayman</i>			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Mount Moriah N.C.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Rudolph Plott</i>		<i>Mary Davidson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>Yes Army 1910-31035034-</i>			
17. INFORMANT		Address <i>2406 - 53rd Avenue</i>	
		24 hours.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema. Bilateral Hydrothorax.</i>		24 hours.	
DUE TO <i>420.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction. Occlusion of rt. coronary.</i>		2 weeks.	
DUE TO <i>420.1</i>			
(c) <i>Coronary Arteriosclerotic Heart Disease.</i>		years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 18, 1959</i> to <i>April 19, 1959</i> , that I last saw the deceased alive on <i>April 19, 1959</i> , and that death occurred at <i>10:20 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>6124 Central Av. Capitol Heights P.G. Md.</i> DATE SIGNED	
ACTUAL SIGNATURE <i>Peter Duus</i> M.D.			
PHYSICIAN'S NAME (Type) Dr. Peter Duus			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-8-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Natl.</i>		22d. LOCATION (City, town, or county) <i>Arlington Va</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lummons Bros.</i>		ADDRESS <i>1661 Good Hope Rd SE Washington DC</i>	
		24a. REC'D BY REGISTRAR DATE <i>APR 7 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

1

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a ~~burial permit~~ permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the ~~burial permit~~ permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Lanham	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb $\frac{1}{2}$ hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS X Lanham	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ruth Vassie Podesta		First Ruth	Middle Vassie
4. DATE OF DEATH April 9,		Last Podesta	Month Month
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-22-58 1900		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carlos Stokes		14. MOTHER'S MAIDEN NAME Sarah Emma Hickman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. Alma Uomini; Decatur Heights, Maryland	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Acute congestive heart failure	
DUE TO (c)		Cardiovascular renal disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		April 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF April 10, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Brooklyn		22d. LOCATION (City, town, or county) New York	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE APR 13 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4687

CERTIFICATE OF DEATH

64694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 5453 Madison Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clarence Elmer Polhamus		First	Middle	Last	4. DATE OF DEATH April 17 1959	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1st, 1896	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Custodian		10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) Modena, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Polhamus		14. MOTHER'S MAIDEN NAME Martha Schoemaker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW1 Unknown		17. INFORMANT Frances C. Polhamus, 5453 Madison Way, Hyattsville P.O. Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Acute myocardial infarction 30 min.							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerotic heart disease 10 yrs.							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4410 34th Ave		(County) Fairmount	(State) Md.
21. I certify that I attended the deceased from 2/9/1952 to 4/17/1959 , that I last saw the deceased alive on 4/17/1959 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 4410 34th Ave, Fairmount Hills, Md.									
DATE SIGNED 4/12/13									
ACTUAL SIGNATURE F. E. Musser									
PHYSICIAN'S NAME (Type) F. E. Musser									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/1959		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Prince George's Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Riverside Md., 5801 Cleveland Ave		24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur & Sons			

TRANSACTION STATEMENT OF HERTZ CORPORATION 18

CERTIFICATE OF DEBT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4646

CERTIFICATE OF DEATH

04695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE	c. LENGTH OF STAY IN 1b 5 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 HYATTSVILLE	d. STREET ADDRESS 5029-37TH AVE.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3029-37TH AVE.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Nini	First	Middle	Last					
4. DATE OF DEATH PREZZI	Month	Day	Year					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-89	9. AGE (In years last birthday) yrs. 69	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) AUSTRIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH PREZZI	14. MOTHER'S MAIDEN NAME JUSTINA							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 578-26-4234	17. INFORMANT VIRGIL PREZZI - 6914-28th Pl., Lewistown Rd.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X		Canceroma of the rectum				INTERVAL BETWEEN ONSET AND DEATH 8 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bladensburg	20f. (City or town) Bladensburg	(County) Prince George	(State) Maryland
21. I certify that I attended the deceased from Aug 19, 1959 to Sept 1, 1959 , that I last saw the deceased alive on Aug 31, 1959 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 35-2440 Rockville, Maryland	DATE SIGNED Sept 1, 1959	
ACTUAL SIGNATURE G. Chester Brady	M.D. 35-2440 Rockville, Maryland							
PHYSICIAN'S NAME (Type) T. CHESTER BRADY								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-4-59	22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN	22d. LOCATION (City, town, or county) Bladensburg, Maryland	(State) Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulon - 3831-GA AVE N.W.		ADDRESS	24a. REC'D BY REGISTRAR DATE APR 7 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas				

470

1X
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04696

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY	4727 Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland	b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Camp Springs 30 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Camp Springs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	5885 Allentown Rd			d. STREET ADDRESS	5885 Allentown Rd		
3. NAME OF DECEASED (Type or print)	First Rhody	Middle Orme	Last Pylex	4. DATE OF DEATH	Month April	Day 15	Year 1959
5. SEX Male	6. COLOR OF RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct 9, 1898	9. AGE (In years less birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>			Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
Plumber	U.S. Govt.	Maryland	U.S.A.				
13. FATHER'S NAME Thomas Pyles	14. MOTHER'S MAIDEN NAME Dolly Tonle						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Adelia G. Pyles, same as above				
W.W. I							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis							
Conditions, if any, which gave rise to immediate cause (a), sloing the underlying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	James I. Boyd			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED April 15, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)			
Burial	4-18-59	Bells Meth Cemetery	Camp Springs	Md.			
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE				
Leimmons Bros.	1661 Good Hope Rd SE Washington DC	DATE APR 17 '59	Arthur L. Krause				

THE CEDAR LANE — **THE CEDAR LANE** — **THE CEDAR LANE**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4728

CERTIFICATE OF DEATH

04697

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		2	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. LENGTH OF STAY IN lb 3YRS, 10MOS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD		d. STREET ADDRESS 33 FENTON PL. N.W.	
First MIDDLE Last ROBINSON		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX MALE		6. COLOR OR RACE N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4/22/05	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIN SETTER		10b. KIND OF BUSINESS OR INDUSTRY BOWLING ALLEY	
10c. BIRTHPLACE (State or foreign country) DIST. OF COLUMBIA		11. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME CHARLES ROBINSON		14. MOTHER'S MAIDEN NAME JENNIE FOSTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 578-03-9617	
17. INFORMANT DECEASED		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 10 MIN.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO PULMONARY HEMORRHAGE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO PULMONARY TUBERCULOSIS		7MOS, 10MOS.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on		to , that I last saw the deceased alive on , and that death occurred at , from the causes and on the date stated above.	
ACTUAL SIGNATURE MOE WEISS, M.D.		ADDRESS (Street, city or town, state) GLENN DALE HOSP. DATE SIGNED 4/19/59	
PHYSICIAN'S NAME (Type)		GLENN DALE, MD.	
22a. (OPTIONAL) Cremation, Removal (Specify) 4/19/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Mullan and Schey Inc		ADDRESS 4249 Post NW	
F.M.C. inc. (Signature)		24a. REC'D BY REGISTRAR DATE APR 21 59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hansen	

CERTIFICATE OF DEATH

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4729

CERTIFICATE OF DEATH

04698

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 year and 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Noel	Middle O.	Last Roeser
4. DATE OF DEATH	Month 4	Day 24	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/03
9. AGE (In years lost birthday) 56 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Odd jobs	12. BIRTHPLACE (State or foreign country) Oklahoma
13. FATHER'S NAME Peter Roeser	14. MOTHER'S MAIDEN NAME Fannie Wellington		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 1942 - 1945	17. INFORMANT Decedent	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Bronchogenic carcinoma, left lung, with metastasis to liver, bony skeleton, and lymph nodes. INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART I. DEATH WAS CAUSED BY: 162.1		IMMEDIATE CAUSE (a), stating the underlying cause lost. (b) DUE TO (c)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis; right upper lobectomy, 1/22/59, for tuberculosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/16 , 19 58 , to 4/24 , 19 59 , that I last saw the deceased alive on 1/23 , 19 59 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Moe Weiss (M. D.) DATE SIGNED 4/24/59			
ACTUAL SIGNATURE Moe Weiss (M. D.)	PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		
22a. BURIAL CREMATION, REMOVAL (Specify) 4/28/59	22b. DATE THEREOF 4/28/59	22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT'L CEM. FT. MYER VA.	22d. LOCATION (City, town, or county) (State) Glenn Dale, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 1400 Chancery St.	ADDRESS NW	24a. REC'D BY REGISTRAR DATE APR 28 '59	24b. REGISTRAR'S SIGNATURE Arthur & Kraus

MANAGING STATE DETERMINATION OF HEALTH-SAVINGS

CERTIFICATE OF DEATH

1-28

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**FOR STATE
HEALTH DEPT.**

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

099

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04699

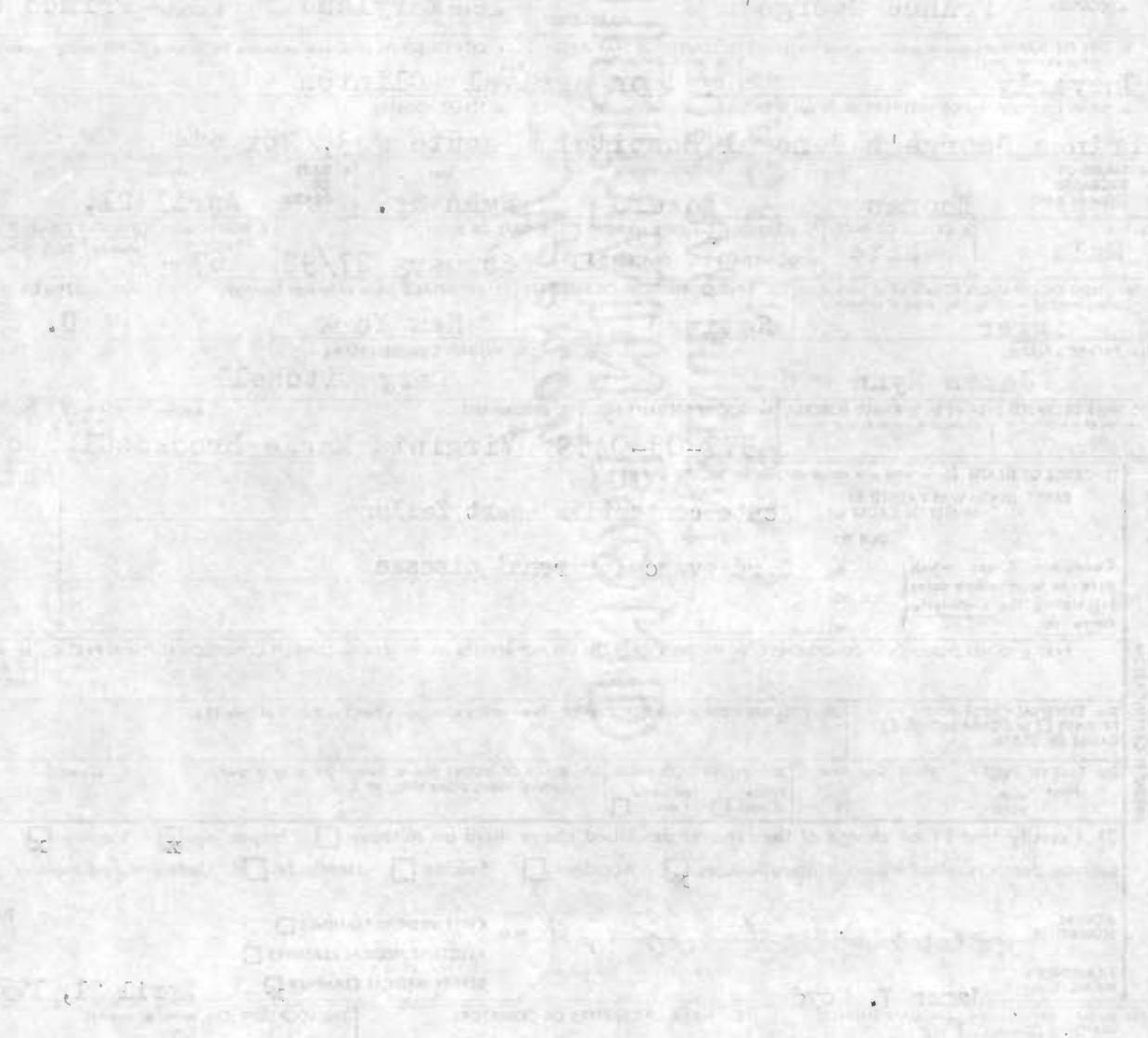
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cheverly		Dead on arrival Clinton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Prince George's General Hospital		Route # 3, Box 644					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Doy	Year
Thomas	Edward	Rynn Sr.		April 21,			1959
5. SEX	6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	White	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		February 27/92	67 yrs.	Months Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Rigger		Retired		New York		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
James Rynn		Mary Mitchell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Rt# 3 Box 594	
No		577-05-0459		Virginia Marie BrookesClinton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure							
442X DUE TO							
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease							
(a), stealing the underlying cause last.							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>		EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 21, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4-24-59		22b. DATE THEREOF 1959		22c. NAME OF CEMETERY OR CREMATORIAL <i>Johns</i>		22d. LOCATION (City, town, or county) (State) <i>Clinton, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald A. Mattingly Wash. D.C.</i>		ADDRESS 131-1188		24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thorne</i>	

BY SPANNING THE GAP IN HUMANITY

REGISTRATION NUMBER 8803

DATE FOR
THE HUMAN



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4689

CERTIFICATE OF DEATH

04700

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
PRINCE GEORGE MARYLAND		MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LAUREL		c. LENGTH OF STAY IN 1b adm. 1-10-59		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. STREET ADDRESS 7121 Willow Ave		
3. NAME OF DECEASED (Type or print)		First CATHERINE	Middle H. S. MUEES	
4. DATE OF DEATH April 3 1959		Month April	Day 3	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1861	
9. AGE (In years from birthday) 97	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORMER HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		
13. FATHER'S NAME DAVID HUGHES	14. MOTHER'S MAIDEN NAME ANN DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Hospital Records	Address LAUREL SANITARIUM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychosis				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3 days Many years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Laurel	(County) (State)
19				
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>April 3</u> , 19 <u>59</u> that I last saw the deceased alive on <u>April 3</u> , 19 <u>59</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.				
ACTUAL SIGNATURE ERIKA P. KRAMER	ADDRESS (Street, city or town, state) Laurel Sanitarium			DATE SIGNED 4-3-59
PHYSICIAN'S NAME (Type)	ERIKA P. KRAMER Laurel Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 6, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Oaklawn Cemetery	22d. LOCATION (City, town, or county) Baltimore County Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St W. 10S	ADDRESS	24a. REC'D BY REGISTRAR APR 6 '59	24b. REGISTRAR'S SIGNATURE C. E. Knott	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04701

4647

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Washington D.C.</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartsville</i>		c. LENGTH OF STAY IN 1b <i>3 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Manor-</i>		d. STREET ADDRESS <i>Kennedy - Warren</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Anna</i>		First	Middle	Last	DATE OF DEATH <i>April 12 1959</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Jan. 1 1899</i>		9. AGE (In years last birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Norfolk, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>		
13. FATHER'S NAME <i>Dr. Thomas Bryson Ward</i>		14. MOTHER'S MAIDEN NAME <i>Julia Paul</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <i>579-16-4881</i>		17. INFORMANT <i>Mrs. Nancy Weir</i>		21. Hesketh St. Chevy Chase, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		acute coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Coronary arteriosclerosis				10 yrs.		
DUE TO (c)		Generalized arteriosclerosis				10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1953</i> to <i>April 12 1959</i> that I last saw the deceased alive on <i>April 12 1959</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>3000 Town Ave. Wash. D.C.</i>		
ACTUAL SIGNATURE <i>Thomas F. McNamee M.D.</i>						DATE SIGNED <i>Thomas F. McNamee M.D.</i>		
PHYSICIAN'S NAME (Type) <i>Thomas F. McNamee M.D.</i>								

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-15-59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NAT'L</i>	22d. LOCATION (City, town, or county) <i>FORT MYER VIRGINIA</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jos. Brewster</i>	ADDRESS <i>Wash. D.C.</i>	24a. REC'D BY REGISTRAR DATE <i>APR 15 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur & Kress</i>	

AT EIGHTH AND FIFTH STREET ON THE TRAILED STATE OF CALIFORNIA

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18
FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

104702
Reg. Dist. No.

4730

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or filed. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4. DATE OF DEATH Month Day Year	
Prince George's MARYLAND		April 12 1959	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
Clinton		b. COUNTY Prince George's	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Clinton	
11 years		d. STREET ADDRESS Maryland Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland Avenue			
3. NAME OF DECEASED (Type or print)		First	Middle
Henry Ludwig Seitz			
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED		8. DATE OF BIRTH	
<input checked="" type="checkbox"/>		Aug 20 1879 99 yrs.	
WIDOWED		DIVORCED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Gardener		Retired	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Germany		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Seitz		Sarah Anna Scherzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		318-05-3059	
17. INFORMANT		Address	
Sister M. Seitz, same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
442 X DUE TO Acute congestive heart failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO Cardiovascular renal disease (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED April 12, 1959	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
220. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
CREMATION		4/15/59	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Fort Lincoln Cemetery		College Haven Rd 600 Lt 40	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
W.W. Chambers Co - 517-115756, West. DE.		24b. REGISTRAR'S SIGNATURE Ollie S. Thomas	
VS. A15ME SM 2/57		DATE APR 14 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04704

4690

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Carrollton)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 5913 85th Place.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Darlene Kay		First Middle Last		4. DATE OF DEATH April 2 19 59		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 31 March 1959	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME William Eugene Shaklee				14. MOTHER'S MAIDEN NAME Rose Marie Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 762.1 DUE TO <i>Respiration</i> <i>Atelectasis</i> <i>2 1/2 days</i> Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. } (b) } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 March 1959 to 2 April 1959, that I last saw the deceased alive on 2 April 1959, and that death occurred at 6:30A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. W. Perkins</i>		ADDRESS (Street, city or town, state) M.D. 5301 Hamilton St., Hyattsville		DATE SIGNED 4/2/59			
PHYSICIAN'S NAME (Type) Dr. J.W. Perkins, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/59		22c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4731

CERTIFICATE OF DEATH

04705

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Maryland Park		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 65th St.		d. STREET ADDRESS 302 65th St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Leonie	Middle M.	Last Shepherd	4. DATE OF DEATH April 24, 1959	Month Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1902	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Nul Grant		14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Flora N. Harpine 302 65th St. Md. Park	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction - 3w 4 days		INTERVAL BETWEEN ONSET AND DEATH 10"			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) 4400 Boucard Rd. SE. D.C.			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/15, 1956, to Present 19_____, that I last saw the deceased alive on 4/28, 1957, and that death occurred at 2 AM 4/28/57 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4400 Boucard Rd. SE. D.C. DATE SIGNED Thomas J. Reiter					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/59	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Prince George	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home 4812 Ga. Ave. N.W. D.C.		ADDRESS		24a. REC'D BY REGISTRAR MAY 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MANITOBA STATE GOVERNMENT OFFICE OF THE ATTORNEY GENERAL

CERTIFICATE OF DEATH

Date of death:

Place of death:

Cause of death:

Name of physician:

Name of hospital:

Name of coroner:

Name of funeral director:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name of coroner's office:

Name of medical examiner:

Name of pathologist:

Name of toxicologist:

Name of laboratory:

Name:

Address:

City:

Prov:

Postal code:

Phone no.:

Fax no.:

Email address:

Other:

Name:

Address:

City:

Prov:

Postal code:

Phone no.:

Fax no.:

Email address:

Other:

RECORDED IN CORONER'S OFFICE

RECORDED IN MEDICAL EXAMINER'S OFFICE

RECORDED IN PATHOLOGIST'S OFFICE

RECORDED IN TOXICOLOGIST'S OFFICE

RECORDED IN LABORATORY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4691

CERTIFICATE OF DEATH

04706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 43 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 2017 Patterson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First James	Middle O	Last Short	4. DATE OF DEATH	Month April	Day 3	Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 20 Feb 1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Steamfitter		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Short			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Helen Y. Hill, 4004--92nd St., Landover, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
<i>Pulmonary embolus</i> <i>Henry Abens - Smichowicz.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2-1 , 19 48 , to 4-2 , 19 59 , that I last saw the deceased alive on 4-3-59 , and that death occurred at 5:55 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>A. Deitz</i>		ADDRESS (Street, city or town, state) <i>Hill, Md.</i> DATE SIGNED <i>4-3-59</i>						
PHYSICIAN'S NAME (Type) Dr. A. Deitz., M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1959		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland Road, Pr. Geo. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Thomas		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		
				DATE APR 6 '59				

BY AUTOMATIC TELEGRAPHIC STATE CHANNEL

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME

DECEASED PERSON'S ADDRESS

DECEASED PERSON'S AGE

DECEASED PERSON'S GENDER

DECEASED PERSON'S RACE

DECEASED PERSON'S RELIGION

DECEASED PERSON'S OCCUPATION

DECEASED PERSON'S MARRIAGE STATUS

DECEASED PERSON'S PARENTS' NAMES

DECEASED PERSON'S SIBLINGS' NAMES

DECEASED PERSON'S CHILDREN'S NAMES

DECEASED PERSON'S SPouse'S NAME

DECEASED PERSON'S SPouse'S ADDRESS

DECEASED PERSON'S SPouse'S AGE

DECEASED PERSON'S SPouse'S GENDER

DECEASED PERSON'S SPouse'S RACE

DECEASED PERSON'S SPouse'S RELIGION

DECEASED PERSON'S SPouse'S OCCUPATION

DECEASED PERSON'S SPouse'S MARRIAGE STATUS

DECEASED PERSON'S SPouse'S PARENTS' NAMES

DECEASED PERSON'S SPouse'S SIBLINGS' NAMES

DECEASED PERSON'S SPouse'S CHILDREN'S NAMES

DECEASED PERSON'S SPouse'S SPouse'S NAME

DECEASED PERSON'S SPouse'S SPouse'S ADDRESS

DECEASED PERSON'S SPouse'S SPouse'S AGE

DECEASED PERSON'S SPouse'S SPouse'S GENDER

DECEASED PERSON'S SPouse'S SPouse'S RACE

DECEASED PERSON'S SPouse'S SPouse'S RELIGION

DECEASED PERSON'S SPouse'S SPouse'S OCCUPATION

DECEASED PERSON'S SPouse'S SPouse'S MARRIAGE STATUS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4692

CERTIFICATE OF DEATH

04707

Reg. Dist. No.

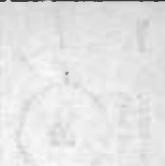
1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES R		4. DATE OF DEATH APRIL 7 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 11, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Funeral Director	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R Shultz		14. MOTHER'S MAIDEN NAME Laura Hendrix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Florence D Shultz	
17. INFORMANT College Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Pulmonary Edema (c) Acute Gastro-Enteritis DUE TO (b) Cerebral Thrombosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 6, 1959 , to APRIL 8, 1959 , that I last saw the deceased alive on APRIL 6, 1959 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.C. ETIENNE		ADDRESS (Street, city or town, state) 4713-Berwyn Rd	
PHYSICIAN'S NAME (Type) W.C. ETIENNE		DATE SIGNED 4-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 4/8/59	
22c. NAME OF CEMETERY OR CREMATORIUM Brazil		22d. LOCATION (City, town, or county) (State) Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR APR 10 1959		24b. REGISTRAR'S SIGNATURE	

STATE OF TEXAS - DEPARTMENT OF PUBLIC SAFETY

CERTIFICATE OF DEATH

DEATH

DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4732

CERTIFICATE OF DEATH

04708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY P.H.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		d. STREET ADDRESS 2200 Hannon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HELEN	Middle A	Last SMITH	4. DATE OF DEATH	Month April	Day 29	Year 19 59	
S. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10 Aug 1917	9. AGE (In years from birthday) 41 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House wife		11. BIRTHPLACE (State or foreign country) Toledo, Ohio		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry P. Fuhrer				14. MOTHER'S MAIDEN NAME Adelyne Last name unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband		Address Chauncey W. Smith		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 15 Hrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 581.0 (b) Esophageal Varices						3 Hrs.		
DUE TO (c) Cirrhosis of the Liver								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 29 Apr , 19 59 , to 29 Apr , 19 59 , that I last saw the deceased alive on 29 Apr , 19 59 , and that death occurred at 7:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) William S. Vaun M.D. USAF Hospital Andrews DATE SIGNED 29 Apr 59								
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) WILLIAM S. VAUN, CAPT, USAF (MC) Andrews AFB Washington 25, D.C.						
22a. BURIAL, Cremation REMOVAL (Specify) Bur-Rem		22b. DATE THEREOF 5-1-59		22c. NAME OF CEMETERY OR CREMATORIUM Fernwood Cemetery		22d. LOCATION (City, town, or county) (State) Henderson Kentucky		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Lewis, Son 1756 Pa. Ave. N.W.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur & Anna		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3735 CERTIFICATE OF DEATH

NAME OF DECEASED		NAME OF MEDIATOR	
JAMES WALTER COOPER		JOHN J. KELLY	
ADDRESS		ADDRESS	
100 E. 20TH ST.		100 E. 20TH ST.	
NEW YORK, N.Y.		NEW YORK, N.Y.	
AGE		AGE	
50 yrs.		50 yrs.	
SEX		SEX	
MALE		MALE	
MATERIAL TESTED		TESTS MADE	
BLOOD		BLOOD	
TIME OF DEATH		TIME OF DEATH	
APRIL 10, 1900		APRIL 10, 1900	
CAUSE OF DEATH		CAUSE OF DEATH	
ACUTE RHEUMATIC CARDIOPATHY		ACUTE RHEUMATIC CARDIOPATHY	
TIME OF AUTOPSY		TIME OF AUTOPSY	
APRIL 10, 1900		APRIL 10, 1900	
SIGNATURE OF MEDIATOR		SIGNATURE OF MEDIATOR	
JOHN J. KELLY		JOHN J. KELLY	
WITNESSED BY		WITNESSED BY	
A. J. H. A.		A. J. H. A.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4733

CERTIFICATE OF DEATH

14709

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale		c. LENGTH OF STAY IN lb X	
d. NAME OF HOSPITAL (If not in hospital, give street address) ORGANIZATION 4807 Russell Avenue		d. STREET ADDRESS 4807 Russell Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sylvester	Middle MacPhillan	Last Smith
4. DATE OF DEATH	Month April 26,	Day Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1884
9. AGE (In years last birthday) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. CITIZEN OF WHAT COUNTRY? U.S.A.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		
10b. KIND OF BUSINESS OR INDUSTRY Fruit Growers Express		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
13. FATHER'S NAME Charles A. Smith		14. MOTHER'S MAIDEN NAME Elizabeth B. Broomall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Amanda Smith- Avondale, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Coronary Artery Heart Disease INTERVAL BETWEEN ONSET AND DEATH Immediate 1-2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ Dec 1957, to April 26 1959, that I last saw the deceased alive on April 2, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7105 Riggs Rd. Hyattsville, Md.	
ACTUAL SIGNATURE Physician's NAME (Type)	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/1959	22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Prince Georges Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE APR 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knue

AI 350M1748-718159 9WBAD16997 31AT2 09A1Y823

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4693

CERTIFICATE OF DEATH

04710

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 3110 Upshur St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Warren	Middle E.	Last Smith	4. DATE OF DEATH April 11 1959	Month Day Year	Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan 19/1874	9. AGE (in years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Book Binder		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Zopher Smith				14. MOTHER'S MAIDEN NAME Ann MacCauley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth H Wife		Address Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Cerebral thrombus INTERVAL BETWEEN ONSET AND DEATH 12h Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arterio-venous hemangioma 20 yrs (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 610 43rd Ave		20f. (City or town) Hyattsville		(County) Hollywood Rd	(State) Md.
21. I certify that I attended the deceased from 4-10-39 , 19, to 4-11-39 , 19, that I last saw the deceased alive on April 11 1959 , and that death occurred at 4:20A M , from the causes and on the date stated above.									
ACTUAL SIGNATURE John P. Clum		ADDRESS (Street, city or town, state) 4739 Baltimore Ave.							DATE SIGNED 4-11-39
PHYSICIAN'S NAME (Type) Dr. Clum									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/13/59	22c. NAME OF CEMETERY OR CREMATORIUM George Washington		22d. LOCATION (City, town, or county) Hyattsville		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 13 59	24b. REGISTRAR'S SIGNATURE Arthur E. K.				

DEPARTMENT OF GENERAL PLANNING

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4694

CERTIFICATE OF DEATH

04711
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
<i>Rhine George</i> Laurel Maryland		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY				
<i>Laurel</i>	<i>20 yrs</i>	<i>P. Geo.</i>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				
		<i>41 Laurel</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<i>339 Laurel Avenue</i>		<i>339 Laurel Avenue</i>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
<i>Ida W. Springgate</i>						
4. DATE OF DEATH	Month	Day	Year			
<i>April 29</i>			<i>1959</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<i>F</i>	<i>W</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>Divorced <input type="checkbox"/></i>	<i>Oct 26 1871</i>	<i>87 yrs.</i>	<i>Months Days Hours Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>		<i>Name</i>		<i>Grayson Co. Kentucky</i>		<i>USA</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
<i>Frank Wilkerson</i>		<i>Kitty Eskridge</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
<i>No</i>				<i>Mrs Catherine DePare, Laurel Md</i>		<i>339 Laurel Ave</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
<i>420.1</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO (b) <i>Coronary Thrombosis</i>						
DUE TO (c) <i>Hypertension & Hypertonic Heart Disease</i>						
INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/12/59</i> , 1959, to <i>4/29</i> , 1959, that I last saw the deceased alive on <i>4/21/59</i> , 1959, and that death occurred at <i>10th</i> M, from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <i>314 Compton ave</i>						
DATE SIGNED <i>4/30/59</i>						
ACTUAL SIGNATURE <i>D.B. Fernandes</i>						
PHYSICIAN'S NAME (Type) <i>N B Steward</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 4, 1959</i>		22c. NAME OF CEMETERY OR CEMETORY <i>Evergreen Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Lamoniville Kentucky</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Donaldson, Laurel, Md</i>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>
				DATE MAY 4 '59		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

67. FROM THE MOUNTAIN STATE CHARTER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04712

4695

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Rt. 2 Box 87		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First Lula	Middle	Last Sweeney	4. DATE OF DEATH April 13 1959	Month	Day	Year
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 19 June 1906	9. AGE (in years last birthday) 52 <input checked="" type="checkbox"/> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Tenent	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Robert Sweeney (Rt. #2, Box 87, Upper Marlboro, Maryland)	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Advanced metastatic carcinomatosis DUE TO (c) Primary carcinoma of colon (Spleen please.) 1 year - ?		INTERVAL BETWEEN ONSET AND DEATH 10 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from 3-9-, 1959, to 4-12-, 1959, that I last saw the deceased alive on 4-12-, 1959, and that death occurred at 4:35 AM, from the causes and on the date stated above.				
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ACTUAL
SIGNATURE *George H. McLain* ADDRESS (Street, city or town, state) *1746 K St. N.W. - Wash. D.C.* DATE SIGNED *4/13/59*

PHYSICIAN'S NAME (Type) Dr. George McLain, Md. D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/59	22c. NAME OF CEMETERY OR CREMATORIUM Epiphany Cemetery	22d. LOCATION (City, town, or county) Forestville, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 24 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur & Thorne</i>
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DEPARTMENT OF STATE GOVERNMENT OF HAWAII - CALIFORNIA 18

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4734

CERTIFICATE OF DEATH

104713

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Richmond	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warsaw		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSIE		First FRANCE	Middle TALLENT	Last	4. DATE OF DEATH Month Day Year April 13, 1959		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Joseph France				14. MOTHER'S MAIDEN NAME Lenica Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Berkshire, Md. Wilbur McPherson-3900 75th Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO <i>Lenica</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <i>Congestive heart failure</i> DUE TO <i>Generalized arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH 6 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 1958</i> to <i>April 13, 1959</i> , that I last saw the deceased alive on <i>April 4, 1959</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Bernard Katzen</i>		M.D. 3550-H. N.Y. - C. S. E. 4-13-59. W.H.L.-D.C.					
PHYSICIAN'S NAME (Type) <i>BERNARD KATZEN M.D. - 3550-H. N.Y. - A.Y. 3. G. W.H.L.-D.C.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-15-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Menokin Baptist Cem</i>		22d. LOCATION (City, town, or county) <i>Ethel, Virginia</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryan, Inc. 317 Pa. Ave., SE DC3</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <i>APR 14 '59</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

MISSOURI STATE DEPARTMENT OF HEALTH—CERTIFICATE OF DEATH

CERTIFICATE OF DEATH



DEATH CERTIFICATE

NAME OF DECEASED

MATERIAL TESTED

TESTS MADE

Date of Birth
Place of Birth
Cause of Death
Name of Physician

Signature

Signature

Signature

Signature

Signature

Signature

Signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04714

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4695													
1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lanham									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 8915 Hickory Hill Avenue								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First Middle Andrew		Last Terry		4. DATE OF DEATH April 5,		Month Year 1959					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1902		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William A. Terry		14. MOTHER'S MAIDEN NAME Mary Elizabeth Achemir											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) Yes		16. SOCIAL SECURITY NO. W.W.2		17. INFORMANT William A. Terry; 3rd		Address 506 Whitfield Chapel Road Lanham, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While or work <input type="checkbox"/> Not while or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 6, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Arlington							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. H.attsville, Md.		24a. REC'D BY REGISTRAR APR 8 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne							

REACTIVE EXOHYDRO- α -HEXYL-SALILOME.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

WS. A1SME
5M 2/S7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Prince Georges Brentwood		b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellsville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Seland Memorial Hosp		First Middle	
3. NAME OF DECEASED (Type or print)		Last Date of Death Month Day Year	
Kenneth Elwood Thornton Cyril 8 1959		3. SEX Male	
5. SEX Male		6. COLOR OR RACE Col.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-30-59	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years from birthday) yrs. 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Francis Elwood Thornton		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
No			
13. FATHER'S NAME Francis Elwood Thornton		14. MOTHER'S MAIDEN NAME Grace Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Father - Same address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonitis DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/59	
22c. NAME OF CEMETERY OR CREMATORIAL Round Oak		22d. LOCATION (City, Town, or County) (State) Spencerville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodderly		ADDRESS Rockville, Md	
24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Cyrus S. Krause	

WISCONSIN STATE GOVERNMENT - GENERAL
FEDERAL EXAMINER'S CERTIFICATE OF DEATH

WISCONSIN STATE
GENERAL EXAMINER

MAX

DECEASED



STATE OF WISCONSIN
EXAMINER'S CERTIFICATE OF DEATH
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for its designated agent, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04716

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida b. COUNTY Largo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb ½ hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's		d. STREET ADDRESS Rt. # 2 Box 108	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Love Scott Tingley		First Charles	Middle Love Scott
4. DATE OF DEATH April 29, 1959	Month April	Day 29	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1901
9. AGE (In years last birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Insurance Broker	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Tingley Sr.		14. MOTHER'S MAIDEN NAME Anna Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW 11	17. INFORMANT Helen Shipley	Address Same as above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816X Hemorrhage and shock			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:50 a.m. 4/ 29 59		20d. INJURY OCCURRED While work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/> Occupant of an automobile that was in an head on /	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) (County) (State) Upper Marlboro P. B. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 29, 1959
EXAMINER'S NAME (Type) James I. Boyd			
22a. BURIAL, CREMATION, (Indicate which you prefer) Burial	22b. DATE THEREOF 5/1/59	22c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill	22d. LOCATION (City, town, or county) Philadelphia Pa.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR MAY 4 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>

EXAMINER'S CERTIFICATE OF DEATH		STATEMENT	
Name of deceased		Date of death	
John Doe		1980-01-01	
Age at death		Cause of death	
65 years		Natural causes	
Sex		Occupation	
Male		Retired	
Marital status		Religious preference	
Married		Catholic	
Employment		Residence	
None		123 Main Street	
Place of death		Name of physician	
Home		Dr. John Smith	
Relationship to deceased		Signature	
Son		John Doe	

B 1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

114717

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Headmarie		c. LENGTH OF STAY IN 1b Neckmarie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital		e. STREET ADDRESS Box 443 Route 2	
f. NAME OF DECEASED (Type or print) Jennessee Anna Toliver		g. FIRST First	h. MIDDLE Middle
i. SEX Female		j. COLOR OR RACE White	k. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
l. DATE OF BIRTH Feb 23 1875		m. AGE (In years last birthday) 84 yrs.	
n. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Gun Home		o. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Nebraska	
p. FATHER'S NAME Benjamin Gossley		q. MOTHER'S MARRIED NAME Fairbie Turner	
r. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		s. SOCIAL SECURITY NO. 17. INFORMANT Lettie Speller, same as for	
t. DUE TO 442 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		u. DUE TO Acute Congestive heart failure Cardiovascular renal disease	
v. DUE TO INTERVAL BETWEEN ONSET AND DEATH			
w. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
x. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		y. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
z. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		aa. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	ab. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ac. (City or town) (County) (State)
ad. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ae. ACTUAL SIGNATURE James T. Boyd		af. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ag. DATE SIGNED April 5, 1959			
ah. BURIAL, CREMATION, REMOVAL (Specify) Burial		ai. DATE THEREOF 4/8/1959	aj. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL Cemetery Suitland Maryland
ak. LOCATION (City, town, or county) (State)		al. REC'D BY REGISTRAR DATE APR 7 '59	
am. FUNERAL DIRECTOR'S SIGNATURE Martin W. Kysong Co.		an. ADDRESS 1300 N Street Wash D.C. N.W.	
ao. REGISTRAR'S SIGNATURE Arthur S. Trahan			

STATE OF HAWAII - DIVISION OF STATE EXAMINER OF DEATH

STATS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4700 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residenco before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		d. STREET ADDRESS 6001 Pontiac St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Martha	Middle Elizabeth	Last Townsend	4. DATE OF DEATH Month April	Month 13	Day 19	Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1901	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Leeds				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. E. Townsend Jr.		5402 Spring Lane, Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO Massive C.t. Hemmor, huge Acute Gastric Ulcer Stress							
INTERVAL BETWEEN ONSET AND DEATH 2 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension, tachycardia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-4-59 , 19, to 4-13-59 , 19, that I last saw the deceased alive on 3-4-13-59 , 19, and that death occurred at 2:20PM , from the causes and on the date stated above. ACTUAL SIGNATURE William C. Weinrant M.D. ADDRESS (Street, city or town, state) 300 Maryland Rd. Greenbelt DATE SIGNED 4-13-59							
PHYSICIAN'S NAME (Type) William C. Weinrant							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/59		22c. NAME OF CEMETERY OR CREMATORIUM George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS 4739 Baltimore Ave.		24a. REC'D BY REGISTRAR DATE APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4701 CERTIFICATE OF DEATH

04719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake		c. LENGTH OF STAY IN lb 43 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		d. STREET ADDRESS 3200 Kenilworth Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Clara	Middle Octava	Last Van Duzer	4. DATE OF DEATH Month April	Day 19	Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1901	9. AGE (In years last birthday) 88 57 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dury, Md.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Daniel Walker				14. MOTHER'S MAIDEN NAME Ellen Edelin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 577-48-9336		17. INFORMANT Jacob Husband		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congestive Heart Failure (c) Coronary-Arterio Sclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 19 59 , to April 19, 19 59 , that I last saw the deceased alive on April 19, 19 59 , and that death occurred at 6:20A M , from the causes and on the date stated above. ACTUAL SIGNATURE R.D. Bauer, M.D. PHYSICIAN'S NAME (Type) R.D. BAUER, M.D. ADDRESS (Street, city or town, state) Prince Georges General Hospital, 1429/59 DATE SIGNED Chesapeake 111 W. 11/14/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/59		22c. NAME OF CEMETERY OR CREMATORIAL Addison Chapel		22d. LOCATION (City, town, or county) (State) Sedgemoor Pleasant, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Aurora, Md.		24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur & Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by you, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4648

CERTIFICATE OF DEATH

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 Reg. Dist. No.
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1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Prince Georges</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>38 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>		d. STREET ADDRESS <i>14301-28 PL.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hyattsville Convalescent & Rest Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Peter Francis Ward</i>		First	Middle	Lost	4. DATE OF DEATH <i>April 25 1959</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>MAY 3, 1883</i>	9. AGE (In years lost birthday) <i>75 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney, Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>		11. BIRTHPLACE (State or foreign country) <i>Nebraska</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Charles Ward</i>		14. MOTHER'S MAIDEN NAME <i>Mary McGraine</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>33/X</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Peter Ward</i>		Address <i>4301-28 PL.</i>		
18. CAUSE OF DEATH [Enter only one cause per-line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>						INTERVAL BETWEEN ONSET AND DEATH <i>31 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		DUE TO <i></i>						
{ <i></i>		DUE TO <i></i>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Colmar Manor</i>		(County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from _____		3/19, 1959, to 4/25, 1959		that I last saw the deceased alive on 4/25, 1959, and that death occurred at 8:30A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Colmar Manor, Md.</i>		DATE SIGNED <i>4-25-59</i>
ACTUAL SIGNATURE <i>Albert Roth</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>ALBERT ROTH</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/28/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malley's Funeral Home, Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Trahan</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>		
				DATE <i>APR 29 '59</i>				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04721
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 33 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula Williamson		First Lula	Middle Williamson
4. DATE OF DEATH Month April Day 21, Year 1959		5. SEX Female	6. COLOR OR RACE white
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12-13-75	9. AGE (In years from birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Florida
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Alma Armstead, same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 970.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Overdose of sedative (Doriden) (a), stating the underlying cause lost. DUE TO (c)		Address	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was said to have consumed a large quantity of Doriden.	
20c. TIME OF INJURY Month, Day, Year Hour 2:45 p.m. 4-19-59 14.00 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
		20f. (City or town) Bladensburg	(County) Pr. Geo. Md.
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED April 22, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/59	22c. NAME OF CEMETERY OR Crematory COLUMBIA GARDENS
22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS		ADDRESS HYATTSVILLE, MARYLAND	24a. REC'D. BY REGISTRAR DATE APR 24 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

104722

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		4702		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Prince Georges		MARYLAND		o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN IB		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		X Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print)		First Louis	Middle James	Last Wines	4. DATE OF DEATH April 9 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1895	9. AGE (In years lost birthday) 63 yrs.
			<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Govt. Guard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Clinton Wines		14. MOTHER'S MAIDEN NAME Mary Elizabeth Williams		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
Wife-and Medical Record					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO <i>Arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Hypertensive cardiovascular disease</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 13</u> , 1958, to <u>4-9</u> , 1959, that I last saw the deceased alive on <u>4-9</u> , 1959, and that death occurred at <u>A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Dr. Donald R. Purdie</u> M.D.					
PHYSICIAN'S NAME (Type) Dr. Donald R. Purdie		22d. LOCATION (City, town, or county) (State) <u>Colman Manor, Md</u>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22f. DATE THEREOF <u>4/13/59</u>		22g. NAME OF CEMETERY OR CREMATORIAL <u>First Cemetery, Lem.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Lansdown, Laurel, Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 14 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Civins & Evans</u>

CERTIFICATE OF DEATH

DEATH CERTIFICATE

DEATH DATE

NAME

DEATH CERTIFICATE

DEATH DATE: 07/22/2012

DEATH PLACE: BETHESDA, MARYLAND

DEATH TIME: 10:00 AM

NAME: ERIC J. GOLDBECK

AGE: 60

SEX: MALE

CAUSE OF DEATH: HEART DISEASE

EDUCATION:

EDUCATION: HIGH SCHOOL GRADUATE

EDUCATION: HIGH SCHOOL GRADUATE

RELATIONSHIP TO DECEASED:

RELATIONSHIP TO DECEASED:

BROOKLYN, NEW YORK



DEATH DATE:	07/22/2012
DEATH PLACE:	BETHESDA, MARYLAND
AGE:	60
SEX:	MALE
CAUSE OF DEATH:	HEART DISEASE
EDUCATION:	HIGH SCHOOL GRADUATE
RELATIONSHIP TO DECEASED:	SON
BROOKLYN, NEW YORK	

DEATH DATE:	07/22/2012
DEATH PLACE:	BETHESDA, MARYLAND
AGE:	60
SEX:	MALE
CAUSE OF DEATH:	HEART DISEASE
EDUCATION:	HIGH SCHOOL GRADUATE
RELATIONSHIP TO DECEASED:	SON
BROOKLYN, NEW YORK	

DEATH DATE:	07/22/2012
DEATH PLACE:	BETHESDA, MARYLAND
AGE:	60
SEX:	MALE
CAUSE OF DEATH:	HEART DISEASE
EDUCATION:	HIGH SCHOOL GRADUATE
RELATIONSHIP TO DECEASED:	SON
BROOKLYN, NEW YORK	

DEATH DATE:	07/22/2012
DEATH PLACE:	BETHESDA, MARYLAND
AGE:	60
SEX:	MALE
CAUSE OF DEATH:	HEART DISEASE
EDUCATION:	HIGH SCHOOL GRADUATE
RELATIONSHIP TO DECEASED:	SON
BROOKLYN, NEW YORK	

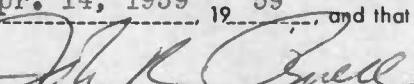
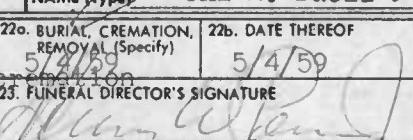
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05952

CERTIFICATE OF DEATH

Reg. Dist. No.

4703

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 hours		d. STREET ADDRESS Route 1 Box 198 (See birth cert.)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General									
3. NAME OF DECEASED (Type or print)		First Baby Girl A	Middle Williams	Last A	4. DATE OF DEATH April 14	Month April	Day 14	Year 1959	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14 1959		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Newborn		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Guy Williams		14. MOTHER'S MAIDEN NAME Joyce Mae Mills							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 776X		16. SOCIAL SECURITY NO.		17. INFORMANT Mother, Joyce Mae Williams, Same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		Preaturity-				INTERVAL BETWEEN ONSET AND DEATH			
DUE TO									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Apr. 14, 1959, to Apr. 14, 1959, that I last saw the deceased alive on Apr. 14, 1959, and that death occurred at 9115A M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 402 Main St.		DATE SIGNED Apr. 15, 59	
ACTUAL SIGNATURE 		M.D.		Laurel, Md.					
PHYSICIAN'S NAME (Type) John R. Buell, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/4/59		22b. DATE THEREOF 5/4/59		22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital, Cheverly		22d. LOCATION (City, town, or county) Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Harry W Penn Jr Administrator		24a. REC'D BY REGISTRAR MAY 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 FROM THE HIGH COURT OF AUSTRALIA STATE OWNERSHIP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4704

CERTIFICATE OF DEATH

05953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George HOWARD ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Route 1 Box 198 (See birth cert.)			
e. IS RESIDENCE ON A FARM? NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Baby	Middle B.	Last Williams	4. DATE OF DEATH April 14 1959	Month April	Day 14	Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1959	9. AGE (In years lost birthday) yrs. 3	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 50	Hours 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Newborn	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Guy Williams				14. MOTHER'S MAIDEN NAME Joyce Mae Mills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 776X		16. SOCIAL SECURITY NO.	17. INFORMANT Mother, Joyce Mae Williams, Same	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 402 Main Street, Laurel, Md.	20f. (City or town) Laurel	(County) Howard	(State) Md.	
21. I certify that I attended the deceased from Apr. 14, 1959 , to Apr. 14, 1959 , that I last saw the deceased alive on Apr. 14, 1959 , and that death occurred at 9:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 402 Main Street, Laurel, Md. DATE SIGNED Apr. 15/59							
ACTUAL SIGNATURE John R. Buell M.D.							
PHYSICIAN'S NAME (Type) John R. Buell, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 5/4/59	22c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital, Cheverly, Md.	22d. LOCATION (City, town, or county) (State) Laurel, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr		ADDRESS Administrator	24a. REC'D BY REGISTRAR MAY 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kimes			

STATE DEPARTMENT OF HANNAH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4735

CERTIFICATE OF DEATH

04723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park avenue		d. STREET ADDRESS Park Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Nannie	Middle - Catherine	Last - Woods		
4. DATE OF DEATH April 5 1959	Month	Day	Year		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16, 1884	9. AGE (In years last birthday) 74 years	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Spangler		14. MOTHER'S MAIDEN NAME Catherine Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no	17. INFORMANT Charles Woods	Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis & Myocardial Infarction</u> INTERVAL BETWEEN 420.0 ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> Year DUE TO (c) <u>Generalized Atherosclerosis</u> Year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>old left hemiplegia - 1950</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colmar Manor, Md.	(County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>April 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>59</u> , and that death occurred at <u>Colmar Manor</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) RFD Box 1100, Bowie, Md.					
ACTUAL SIGNATURE <u>H. James Kortz</u>	M.D.		DATE SIGNED 4/6/59		
PHYSICIAN'S NAME (Type) <u>H. James Kortz</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 7, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			24a. REC'D BY REGISTRAR DATE APR 7 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE AT DEATH	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	51 yrs. 9 mos.	Male	CHL. & PNEUMONIA
ADDRESS	STREET	CITY	STATE
100 W. 10th Street	10th Street	Bethel	Conn.
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL DIRECTOR	NAME OF CEMETERY
DR. JAMES M. COOPER	Hospital	COOPER	COOPER
RELATIONSHIP	DEATH CERTIFIED	DATE	TIME
Son	Yes	Sept. 24, 1918	10:00 A.M.
NAME OF SIGNER	POSITION	STAMP	SEAL
WILLIAM H. COOPER	Witness		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4736

CERTIFICATE OF DEATH

114724

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
Prince Georges MARYLAND		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY		
Rural - Adelphi	2 1/2 months	Alleg. ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Park Branch Nursing Home	Cumberland 21022			
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH	5. SEX	6. COLOR OR RACE	
Louise Catherine Welch	April 13, 1959	F	Caucasian	
			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
			8. DATE OF BIRTH	
			Nov. 3, 1883	
			9. AGE (In years last birthday) yrs.	
			75	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Housewife		Maryland	USA	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address		
William Armbruster	Irene Weir			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
No	none	Nursing Home Records	Coronary Thrombosis	
			DUE TO	INTERVAL BETWEEN ONSET AND DEATH 15 min.
			(b) Arteriosclerotic Cardiovascular Disease	10 yrs.
			(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 18, 1959, to April 13, 1959, that I last saw the deceased alive on April 7, 1959, and that death occurred at 10:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city, or town, state) DATE SIGNED James M. Whiting, M.D. 7701 Carroll Ave. 4-13-59		
ACTUAL SIGNATURE				
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)
Burial	4/16/59	St. Lukes Church Cem.	Cumberland	Maryland
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
J.W. Lees Co.	300 4th St. NE. Wash. D.C.	DATE APR 16 '59	Arthur & Krause	

